

*Fredric A. Washburn*

---

Fifteenth Annual  
Conference

AMERICAN  
HOSPITAL  
ASSOCIATION

Held in Boston, Mass.  
Nineteen Hundred and Thirteen

Vol. XV.

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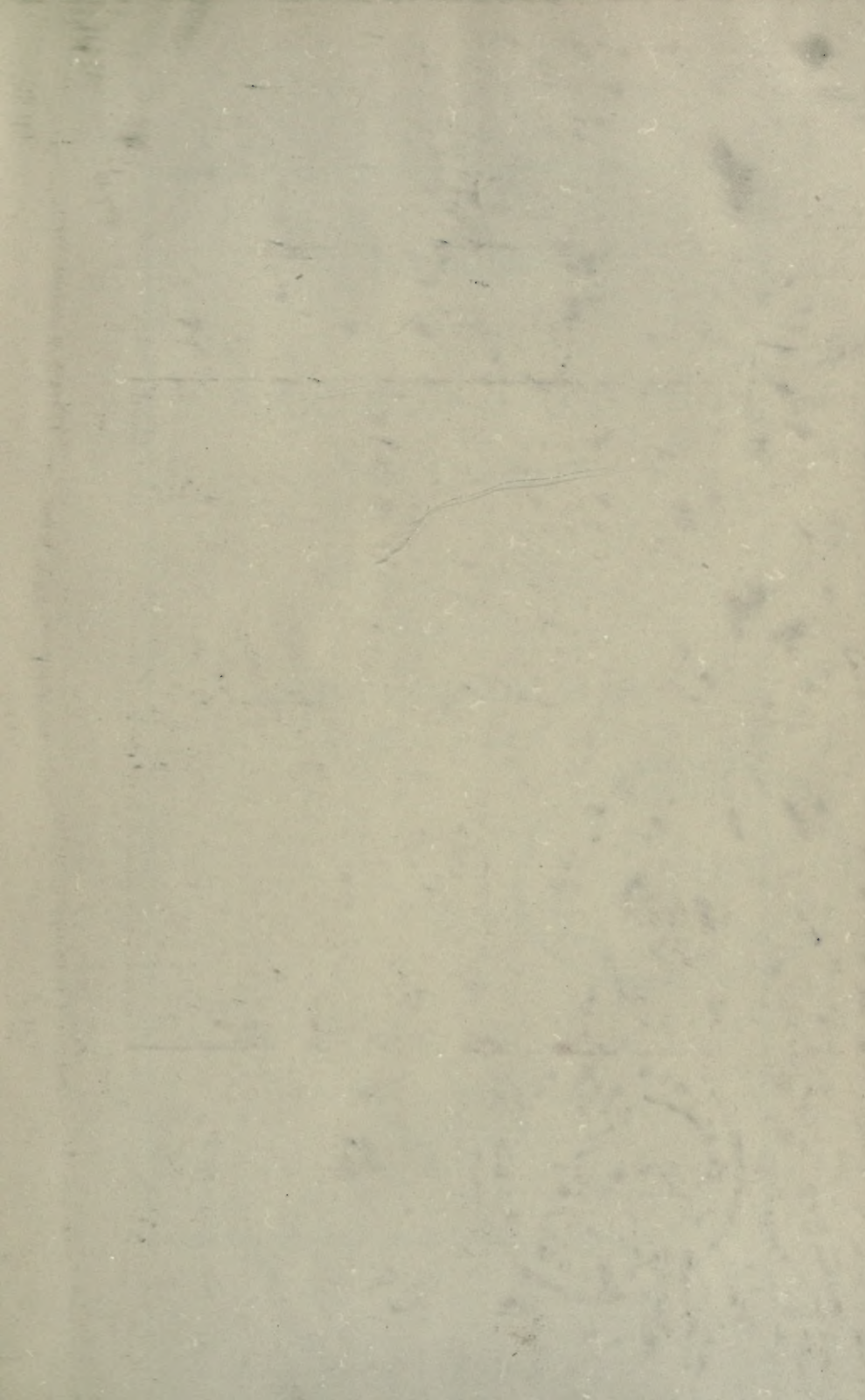
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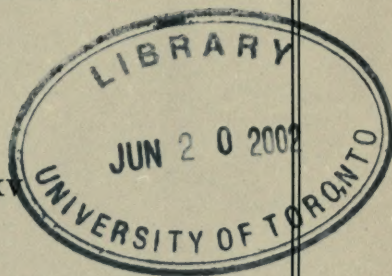
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of the  
American Hospital  
Association

*Fifteenth Annual  
Conference*

HELD IN BOSTON, MASS.,

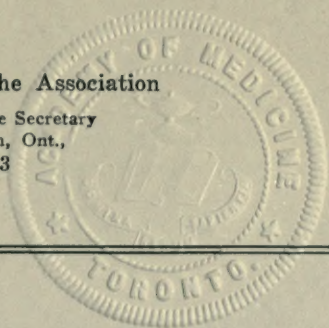
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- MISS LUCY C. AYRES, Supt., Woonsocket Hospital, Woonsocket, R.I.  
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 G. ALDER BLUMER, M.D., Supt., Butler Hospital, Providence, R.I.  
 MISS E. M. FENSTAD, Supt., Woonsocket Hospital, Woonsocket, R.I.  
 E. N. LITTLEFIELD, Trustee, Memorial Hospital, Pawtucket, R.I.  
 JOHN M. PETERS, M.D., Supt., Rhode Island Hospital, Providence, R.I.  
 D. L. RICHARDSON, M.D., Supt., Providence City Hospital, Providence, R.I.  
 MISS M. M. SUTHERLAND, Supt., Memorial Hospital, Pawtucket, R.I.

## SOUTH AFRICA

- GEO. FOSTER, District Hospital, Boksburg, Transvaal, South Africa.  
 CYRIL SENSONS, Res. Sec'y, Pretoria Hospital, Box 201, Pretoria, S. Africa.

## SOUTH CAROLINA

- A. EARL BOOZER, M.D., Supt., Columbia Hospital, Columbia, S.C.  
 DR. L. R. CRAIG, Trustee, Baker-Craig Sanitarium, Charleston, S.C.  
 MISS LEILA V. JONES, Supt., Roper Hospital, Charleston, S.C.  
 MISS MARY E. STELLING, Supt., Anderson County Hospital, Anderson, S.C.  
 MISS MARION UTES, R.N., Supt., Anderson Co. Hospital, Anderson, S.C.,

## SOUTH DAKOTA

- DR. C. P. FARNSWORTH, Supt., Chamberlain Sanatarium, Chamberlain, S.D.  
 H. R. HUMMER, M.D., Supt., Asylum for Insane Indians, Canton, S.D.

## TENNESSEE

- A. E. CLEMENT, Trustee, Galloway Memorial Hospital, Nashville, Tenn.  
 W. C. DIXON, Supt., Vanderbilt University Hospital, Nashville, Tenn.  
 ALICE A. GORMAN, Supt. of Nurses, Baptist Memorial Hospital, Memphis, Tenn. (*Associate.*)  
 CHAS. R. MASON, Supt., Memphis City Hospital, Memphis, Tenn.  
 THOS. S. POTTS, Supt., Baptist Memorial Hospital, Memphis, Tenn.

## TEXAS

- MISS A. LOUISE DIETRICH, Supt., St. Mary's Maternity Hospital, El Paso, Texas.  
 J. B. FRANKLIN, Supt., Baptist Memorial Hospital, Dallas, Texas.  
 DR. J. V. GUYTON, Supt., Guyton Hospital, Plainview, Texas.  
 DR. KENT V. KIBBIE, 9th and Houston Sts., Fort Worth, Texas.  
 JOHN T. MOORE, M.D., Trustee, Texas Christian Sanatorium, Houston, Texas.  
 DR. G. S. MURPHY, Supt., Amarillo Hospital, Amarillo, Tex.  
 DR. Z. T. SCOTT, Supt., Presbyterian Sanitarium, Austin, Tex.  
 J. R. STUART, M.D., Trustee, Houston Infirmary Sanatorium, Houston, Tex.  
 MISS CARRIE WEBSTER, Supt., All Saints' Hospital, Fort Worth, Tex.  
 W. S. WINTER, M.D., Supt., Lake View Hospital, Pt. Arthur, Tex.

## UTAH

- J. J. CATRON, Mgr., St. Mark's Hospital, Salt Lake City, Utah.  
 JOHN WELLS, Supt., Latter Day Saint's Hospital, Salt Lake City, Utah.

## VERMONT

- MISS CLARA J. CHURCHILL, Supt. of Nurses, Mary Fletcher Hospital, Burlington, Vt.  
 HATTIE E. DOUGLAS, Supt. of Nurses, Mary Fletcher Hospital, Burlington, Vt.  
 DR. S. E. LAWTON, Supt., Brattleboro Retreat, Brattleboro, Vt.

- MISS E. MYRTLE MILLER, Asst. Supt., Bright Lake Hospital, St. Johnsbury, Vt.  
 DR. L. B. MORRISON, Asst. Supt., Mary Fletcher Hospital, Burlington, Vt.  
 L. F. PAGE, Trustee, Wilmington Hospital, Wilmington, Vt.  
 MISS MARION G. PARSONS, (address unknown). (*Associate.*)  
 MISS ANNA LOUISE DAVIS, Brattleboro, Vt.  
 MISS MARY SCHUMAKER, Supt., Memorial Hospital, Brattleboro, Vt.  
 MISS NINA A. SMITH, Supt., St. Albans' Hospital, St. Albans, Vt.

## VIRGINIA

- S. G. BENTLEY, Supt., C. & O. Hospital Railway Ass'n., Richmond, Va.  
 MISS CELIA BRIAN, R.N., Supt., General Hospital, Danville, Va.  
 MISS ELEANOR G. EVANS, Supt., Jefferson Surgical Hospital, Roanoke, Va.  
 MISS A. C. MCKAY, Supt., Alexandria Hospital, Alexandria, Va.  
 MISS ESTHER MORGAN, Supt., Dixie Hospital, Hampton, Va.  
 MISS M. A. NEWTON, Supt., Sara Leigh Hospital, Norfolk, Va.  
 CHAS. R. ROBINS, M.D., Member Memorial Hospital, Richmond, Va.  
 MISS M. A. SMITH, Supt., King's Daughter's Hospital, Staunton, Va.  
 HUGH H. TROUT, M.D., Supt., Jefferson Surgical Hospital, Roanoke, Va.  
 MISS ROSE Z. VAN VORT, Memorial Hospital, Richmond, Va.  
 DR. ROWLAND D. WOLFE, Supt., Norfolk Protestant Hospital, Norfolk, Va.

## WASHINGTON

- MRS. MAYNE E. BARRY, Pres., Walla Walla Hospital, Walla Walla, Wash.  
 A. J. BURROWS, Supt., Fannie C. Paddock Memorial Hospital, Tacoma, Wash.  
 MISS EVELYNE H. HALL, Supt., Seattle General Hospital, Seattle, Wash.  
 G. W. OVERMEYER, Supt., Willapa Harbor Hospital, Raymond, Wash.  
 MISS R. C. ROGERS, R.N., Supt., General Hospital, Hoquani, Wash.  
 R. S. WELLS, M.D., Supt., Northport Hospital, Northport, Wash.

## WEST VIRGINIA

- H. F. BEHRENS, Trustee, Wheeling City Hospital, Wheeling, W.Va., Neuralgyline Co.  
 A. S. BOGGS, M.D., Supt., Boggs Hospital and Sanatorium, Gassaway, W.Va.  
 PLINY O. CLARK, Supt., City Hospital, Wheeling, Va.  
 DR. IRVIN HARDY, Trustee, Allegheny Heights Hospital, Davis, W.Va.  
 HOWARD HAZLETT, Trustee, Wheeling City Hospital, Wheeling, W.Va.

## SCOTLAND

- MISS MARGARET BRYDEN, R.N., 127 Sniley Drive, Dunnistown, Glasgow, Scotland.



- DR. MARY B. McCUNE, Supt., Shenandoah Valley Sanitarium,  
Martinsburg, W.Va.  
W.M. F. STIFEL, Trustee, City Hospital, Wheeling, W.Va.  
LEWIS HORNHEIMER, Trustee, Ohio Valley General Hospital,  
Wheeling, W.Va.  
W. B. PETERSON, Trustee, New City Hospital, Wheeling, W.Va.  
W. A. WILSON, Trustee, Wheeling City Hospital, 504 Main St.,  
Wheeling W.Va.

## WISCONSIN

- C. B. CLARK, Trustee, Theda Clark Memorial Hospital, Neenah,  
Wis.  
J. W. COON, M.D., Supt., State Tuberculosis Hospital, Wales,  
Wis.  
HERMAN L. FRITCHEL, Supt., Milwaukee Hospital, 2100 Cedar  
St., Milwaukee, Wis.  
MISS MARY B. HART, Supt., River Pines Sanitarium, Stevens  
Point, Wis.  
MISS ELLA C. INGWERSON, Supt., La Crosse Hospital, La Crosse,  
Wis.  
B. LEIDERSPOFF, Chairman Exec. Com., Columbia Hospital Ass'n,  
Milwaukee, Wis.  
CAROL L. MARTIN, Columbia Hospital, Milwaukee, Wis.  
JOSEPH PURVIS, Madison General Hospital, Madison, Wis.  
C. N. SENN, M.D., Senn Hospital, Ripon, Wis.  
MISS CAROLINA W. SOHN, Asst. Supt., Montgomery Hospital,  
Eau Claire, Wis.  
ELYSIAN THOMAS, Supt., Lake Side Hospital, Milwaukee, Wis.  
MISS REGINE WHITE, Supt., Johnston Emergency Hospital, Mil-  
waukee, Wis.

## HONORARY MEMBERS.

- DEL T. SUTTON, 1899, 157 Alexandrine W., Detroit, Mich.
- ROBERT W. HILL, 1901, Capitol Bldg., Albany, N.Y.
- BYRON W. CHILD, 1902, Capitol Bldg., Albany, N.Y.
- FRANK MILES DAY, 1903, 801 Penn. Mutual Bldg., Philadelphia, Pa.
- FRANKLIN B. KIRKBRIDE, 1903, 37 Madison Ave., New York, N.Y.
- HERBERT G. STOCKWELL, 1904, 833 Land Title Bldg., Philadelphia, Pa.
- PROF. S. HOMER WOODBRIDGE, 1904, Institute of Technology,, Boston, Mass.
- CHAS. G. DARRAGH, 1904, 1430 South 58th St., Philadelphia, Pa.
- J. M. MOSHER, M.D., 1904, 170 Washington Ave., Albany, N.Y.
- SIR HENRY BURDETT, K.C.B., K.C.V.O., 1905, Porchester Square, W., London, Eng.
- FRANK J. FIRTH, 1906, 716 Arcade Bldg., Philadelphia, Pa.
- R. W. BRUCE SMITH, M.D., 1907, Parliament Bldg., Toronto, Ont.
- C. W. PARDEE, 1907, Delaware Ave., Buffalo, N.Y.
- DONALD J. MACKINTOSH, M.B., M.V.O., 1908, Western Infirmary, Glasgow, Scotland.
- HON. FRANK T. LODGE, 1910, Attorney-at-Law, Detroit, Mich.

## CONSTITUTION.

## ARTICLE I.

The name of this Association shall be "The American Hospital Association."

## ARTICLE II

The object of this Association shall be the promotion of economy and efficiency in hospital management.

## ARTICLE III.

*Membership.*

Sec. 1. The membership of this Association shall be active, associate and honorary.

Sec. 2. Active members shall be those who at the time of their election are trustees or executive heads of hospitals, without reference to sex, title or denomination. Any person, once an active member, may continue such membership subject to all rules pertaining to membership.

Sec. 3. Associate members shall be executive officers of hospitals next in authority below the superintendent, contributors to, or officers or members of association, the object of which is the foundation of hospitals or the promotion of the interests of organized medical charities, hospital physicians, surgeons, pathologists and superintendents of nurses. Associate members shall not have the right to vote.

Sec. 4. All applications for membership shall be in writing, and addressed to the Secretary, and shall be endorsed by one or more members of the Association. They shall be referred by the Secretary to the Committee on Membership for examination and report. The candidate shall be notified of the result. If elected, he shall become a member of the Association on payment of an initiation fee of \$5.00, which shall also cover his first dues. Any person once an active member may continue such membership, subject to all rules pertaining to membership.

Sec. 5. Honorary membership may be suggested at any meeting of the Association by any member for any person whose services, public or private, may entitle him to such recognition, or for any other person who, in the judgment of the Association, is entitled to such membership.

Sec. 6. Honorary members shall have all the privileges of active members, except voting. They shall be exempt from the payment of dues.

## ARTICLE IV

The executive officers of the Association shall consist of a President, three (3) Vice-Presidents, a Secretary and a Treasurer.



## ARTICLE VI.

All vacancies occurring in executive offices between conventions shall be filled by the Executive Committee.

## ARTICLE VII.

Amendments to the Constitution shall be submitted in writing. Amendments cannot be acted upon at the session at which they are proposed, but may be at any subsequent session. They shall be passed by not less than two-thirds vote of the members present and voting.

## ARTICLE V.

The executive officers shall be elected at each Convention, and shall serve until the close of the Convention next succeeding, or until their successors are regularly elected and installed.

## BY-LAWS.

## ARTICLE I.

*Meetings.*

Sec. 1. The regular meetings of the Association shall be held at the places and on the dates fixed by the Convention or the Executive Committee of the Association. This committee, in conjunction with the President and Secretary, shall also arrange the programs for the Conventions.

Sec. 2. Special meetings may be called by the President, or, in his absence, by a Vice-President, upon the written petition of not fewer than ten (10) members. This petition shall recite the object of the call. The President, through the Secretary, shall give notice of not less than sixty (60) days before the proposed time of such special meeting to each member of the Association, which notice shall also recite the object of the meeting.

Sec. 3.—A quorum of the Association shall consist of not fewer than thirty (30) members.

## ARTICLE II.

*Elections.*

Sec. 1. All officers shall be elected by ballot, excepting where it is otherwise ordered.

Sec. 2. A majority of the votes cast shall constitute an election.

Sec. 3. Only active members shall be entitled to vote.

## ARTICLE III.

*Duties of Officers.*

Sec. 1. The President shall preside at all meetings of the Association. He shall appoint all committees, unless, by vote of the Association, other provisions shall be made. He shall be *ex-officio*, a member of all standing and special committees.

Sec. 2. The Vice-Presidents shall, in the order of their rank, in the absence of the President, perform his duties.

Sec. 3. The Secretary shall keep the Minutes of the meetings and the records of the Association in a book provided for these purposes. The Secretary shall furnish to the Committee on Publication, within ten (10) days after the adjournment of the regular Convention, a correct copy of the Minutes thereof for publication in the "Proceedings." The Secretary shall be allowed not to exceed the sum of \$600 per annum to defray cost of clerical assistance.

Sec. 4. The Secretary shall conduct the correspondence of the Association, and shall keep on file all letters and all correspondence, together with all replies thereto.

Sec. 5. The Treasurer shall receive all dues and other moneys of the Association, and shall pay all bills approved by the President and Secretary, and shall submit these accounts, together with a financial report, at the regular meeting of the Auditing Committee, after which he shall present this report, with the endorsement of the Auditing Committee, to the Convention. The Treasurer shall be allowed not to exceed the sum of \$120 per annum to defray the cost of clerical assistance.

#### ARTICLE IV.

##### *Committees.*

Sec. 1. The President elected at the regular Convention shall appoint the following standing committees: An Executive Committee of five (5) members; an Auditing Committee of three (3) members; a committee on Nomination of Officers of three (3) members; a Membership Committee of three (3) members; a committee of three (3) on Legislation; a committee on Constitution and Rules of three (3) members; a committee on Hospital Progress of six (6) members; a committee on the Development of the Association of three (3) members, and a Non-Commercial Exhibition Committee of five (5) members, including Chairman.

Sec. 2. The Auditing Committee shall receive and audit all accounts of the Treasurer and all bills contracted on account of the Association, stamp its approval thereon, and return them to the Treasurer for submission to the Convention.

Sec. 3. The Committee on Nomination shall nominate to the Convention the names of candidates for President, three (3) Vice-Presidents, Secretary and Treasurer. The action of this committee is at all times subject to the approval of the Convention.

Sec. 4. The Membership Committee shall receive and consider all names of candidates proposed for membership, and shall report results to the Convention for final action.

Sec. 5. The Committee on Constitution and Rules shall consider and report on all proposed amendments in the Constitution and By-laws and all Rules of Order.

Sec. 6. The Committee on Hospital Progress shall observe the development of hospital work in the United States and Canada and shall submit a report of its observation at the Annual Convention of the Association.

The Committee on Hospital Progress shall be subdivided as follows:

- (a) A committee of one on hospital construction;
- (b) A committee of one on hospital efficiency, hospital finances and the economics of construction;



- (c) A committee of one on medical organization and medical education;
- (d) A committee of one on the training of nurses;
- (e) A committee of one on out-patient work;
- (f) A committee of one on hospital accounting.

Sec. 7. The Committee on the Development of the Association shall present annually a report on the further development of the Association's work.

Sec. 8. The Committee on Legislation shall report annually to the Association on all national and state legislation of interest to hospitals or training schools.

Sec. 9. The Committee on Non-Commercial Exhibits shall arrange annually for an exhibit of non-commercial hospital appliances. The chairman of this committee shall be an officer of the Association, to be appointed by the president for a period of two years, and shall be allowed a sum not exceeding \$250 per annum to defray expenses.

#### ARTICLE V.

##### *Dues.*

Sec. 1. The dues of active members shall be Five Dollars (\$5.00); the dues of associate members shall be Two Dollars (\$2.00). Dues shall be paid to the Treasurer of the Association on or before each regular meeting of the Association.

Sec. 2. Any member delinquent in his dues more than two (2) successive Conventions shall, upon the report of the Treasurer of adequate notification, be suspended from membership.

Sec. 3. The Treasurer shall notify the delinquent of such suspension, and at the same time the Secretary of the Association, who shall enter it upon the records.

Sec. 4. Any delinquent may reinstate himself upon payment of all back dues, as well as those for the ensuing Convention.

#### ARTICLE VI.

##### *Publication of Proceedings.*

Sec. 1. The President shall appoint three active members of the Association as a Publication Committee, one of whom shall be the Secretary of the Association. It shall be the duty of this Committee to edit and publish the annual transactions of the Association.

Sec. 2. The Secretary shall furnish each active and honorary member a copy of this publication.

Sec. 3. The Treasurer shall, upon the certification of the President and Secretary, pay all bills for the printing and publication of the Proceedings of the regular Conventions.

## ARTICLE VII.

*Guests.*

Members of this Association may have the privilege of inviting special guests to the meetings, with the consent of the President. Guests thus introduced shall be permitted to participate in the discussions.

## ARTICLE VIII.

*Discipline.*

Sec. 1. All charges of violation and infraction of rules or unbecoming conduct shall be referred to a special investigating committee appointed by the President.

Sec. 2. Due notice of the charges shall be given to the alleged offender, in writing, by the Secretary of the Association.

Sec. 3. The Association shall have the right and authority to reprimand, suspend and expel any member guilty of violation of any of the provisions of the Constitution or By-laws of the Association, after a full and fair investigation shall have been made.

Sec. 4. A four-fifths vote shall be necessary to sustain the action of such committee.

## ARTICLE IX.

*Order of Business.*

Calling of the Association to order.  
Reading of minutes of the previous Convention.  
Announcements. Unfinished Business.  
Reports of Committees.  
New Business.  
Presentation of Papers, and Discussion.

## ARTICLE X.

*Amendments to By-laws.*

No part of these By-laws shall be suspended, altered, or changed, except as provided for by Article VII. of the Constitution.

**MINUTES OF FIFTEENTH ANNUAL CONFERENCE OF THE AMERICAN HOSPITAL ASSOCIATION.**

**August 26, 27, 28 and 29, 1913.**

**TUESDAY, AUGUST 26—MORNING SESSION.**

Called to order by President Frederic A. Washburn at 10 a.m., August 26th, 1913, at the Copley-Plaza Hotel, Boston, Mass.

Invocation by Suffragan Bishop of Massachusetts Samuel G. Babcock.

Address of welcome by Councilman John J. Attridge, of Boston.

Address by President Washburn.

Report of Committee on Medical Organization and Medical Education was read by Dr. R. B. Seem and discussed by Drs. Howard, Wilson, Winford Smith and Kavanagh.

Motion was made by Dr. Fowler, and carried, that a committee of three be appointed to take up the suggestions made by the President and report at a later session. A vote of thanks was extended to the President for his valuable address.

The President announced the following committees: On Time and Place of Next Meeting, Dr. R. J. Wilson Miss Riddle and Asa Bacon, Esq.; on President's Address, Drs. Fowler, Winford Smith and John M. Peters.

**TUESDAY AFTERNOON.**

The Relation of Hospital Efficiency to the Efficient Organization for Home Nursing. (Paper read by Mr. R. M. Bradley.)

The Grading of Nurses. (Paper read by Miss Mary M. Riddle.)

Report of Committee to Consider the Grading and Classification of Nurses. (Printed report submitted by Miss Emma Anderson.)

Motion made by Dr. Kavanagh that the Committee be continued to work on the report next year, and that Miss Riddle's paper be especially brought to their attention, and that \$500 be appropriated to carry on their work.

Amendment offered by Dr. Mann, that three members be added to that Committee, these members to be men representative of larger hospitals.

Dr. Brown moved an amendment to the amendment, to add three members, superintendents of hospitals, who are graduate nurses, which amendment to amendment was put to vote and lost.

Dr. Kavanagh then accepted Dr. Mann's amendment, which was changed to add to the committee the President of the American Hospital Association and one man superintendent representing the larger hospitals. The motion so amended was then carried.

Dr. Kavanagh gave notice that on Thursday morning he would move that Section 3, Article 4, be struck out of the By-laws and to strike out Section 1 of the Constitution, the words, "The Committee on Nomination of Officers, three members."

Dr. Kavanagh also moved that the election of officers be held Thursday morning, which motion carried.

### WEDNESDAY, AUGUST 27.—MORNING SESSION.

A meeting of the Section of Larger Hospitals was held in the lower amphitheater of the Out-Patient Department of the Massachusetts General Hospital.

The Small Hospitals Section met at the Copley-Plaza Hotel. In the absence of Miss Morrison, Vice-President, the Secretary, Dr. J. N. E. Brown, presided.

How the Small Hospitals May be Made Self-Supporting. (Paper read by Mr. G. W. Olson.)

The paper was discussed by Drs. Cook and Fowler, Miss Jordan, Dr. Wheeler, Mr. Palmer, Miss Harty, Dr. Noyes, Dr. Franklin, Miss Goodnow, Dr. Simons, Miss Abbe, Dr. Mitchell, Mrs. Hayden and Miss Featherstone.

Miss Margaret M. McCore, who was to have read a paper, being absent, the meeting adjourned.



### WEDNESDAY—AFTERNOON SESSION.

Small Hospitals Section (continued).

What the American Hospital Association can do for the Hospitals of America. (Paper read by E. P. Haworth.)

Discussion by Drs. Fowler, Boyce, Mr. Olson, Mr. Borden and Dr. Franklin.

Dr. Fowler moved that a committee of three be appointed to take up the suggestions made in the paper at the next meeting of the Conference. Dr. Mitchell moved as an amendment, that Mr. Olson be placed on that committee, which amendment was accepted and the motion as amended was carried.

The Employment of Third Year Pupils as Special Nurses. By Miss Mary Alberta Baker, R.N. Discussion by Dr. Harris, Miss Abbe and Dr. Boyce.

### WEDNESDAY—EVENING SESSION.

A Round Table Conference for superintendents of small hospitals was held (see proceedings).

Miss Morrison still being absent, Dr. Brown again took the chair, and the questions on the program were discussed by the Chairman, Miss Harty, Dr. Howland, Dr. Cook, Mr. Borden, Miss Thayer, Miss Perry, Miss Parsons, Dr. Kavanagh, Miss Goodnow, Miss Riddle, Mr. Olson, Miss Byrnes, Dr. Ball, Dr. Franklin, Dr. Simons, Dr. Souder, Dr. Davis, Mrs. Lewis and Dr. Haworth.

### THURSDAY, AUGUST 29—MORNING SESSION.

Dr. Washburn presiding.

Report of Membership Committee was read and placed on file.

Mr. O'Brien was substituted on the Nominating Committee in place of Miss Keith, who had notified the President of her inability to be present.

The report of the Committee to make recommendations concerning suggestions in President's address was read by Dr. Fowler. Motion to adopt was seconded, but the President ruled that inasmuch as the

adoption of the report would mean changes in the By-laws, it would have to lie over. Dr. Fowler then gave notice that at the next session he would move to amend Section 3, Article 3, of the Constitution by adding after the word "Charities" in the fifth line, the words "Hospital physicians, surgeons, pathologists and superintendents of nurses."

Motion to adopt report was then put to vote and carried.

Report of Committee to Memorialize Congress was read and accepted.

Reports of Treasurer and Auditing Committee were read and accepted.

Motion by Dr. Kavanagh of which notice had been given Tuesday afternoon, to strike from Article 4, Section 1, the phrase reading, "The President shall appoint a committee on Nomination of Officers of three members," and to strike out Section 3 of Article 4 which reads, "The Committee on Nominations shall" etc., was taken up for consideration and discussed by Drs. Babcock, Kavanagh, Hurd, Fisher and Miss Aikens. The motion was then put to vote and unanimously rejected.

Report of Committee on Out-Patient Departments was read by Mr. Davis and discussed by the President and Dr. Fowler.

The Hospital and Dispensary and Social Reform. (Paper read by Mr. Sidney E. Goldstein and discussed by Dr. Goldwater.)

Medical Workshops as a New Hospital Department. (Paper read by Dr. Herbert J. Hall, of Marblehead, Mass.)

#### THURSDAY—AFTERNOON SESSION.

Dr. Fowler's amendment to the Constitution, admitting to associate membership members of the staffs of hospitals, physicians, surgeons and superintendents of nurses, was called up, put to vote and unanimously adopted.

Report of Committee on Time and Place of Next Meeting was read by Dr. Wilson, the report recommending that the time of meeting be left with the Executive Committee, and that the place of meeting

be Baltimore. Mr. Olson moved as an amendment that St. Paul be substituted for Baltimore, which amendment carried and St. Paul was declared to be the next place of meeting.

The Committee on Nominations reported the following nominees:

For President—Dr. Thomas Howell, New York.

1st Vice-President—H. E. Webster, Montreal.

2nd Vice-President—Miss Mary A. Baker, of Jacksonville, Fla.

3rd Vice-President—Miss Margaret Rogers, St. Louis.

Secretary—Dr. H. A. Boyce, Kingston.

Treasurer—Mr. Asa Bacon, Chicago.

On motion of Dr. Kavanagh, the report of the Nominating Committee was unanimously adopted and the Secretary instructed to cast the ballot of the Association for the nominees.

Resolution submitted by Dr. Goldwater, instructing the Committee on Constitutions and By-laws for the ensuing year to prepare a revised Constitution and By-laws and especially to consider the desirability of providing for the appointment of a paid Secretary, was carried unanimously.

Dr. Hurd offered a resolution for the inspection, classification and standardization of hospitals, which was unanimously adopted. Dr. Hurd stated that it was his desire that the committee be appointed by the incoming President.

Certain Bearings Upon Hospital Problems of Compulsory Insurance and Workmen's Compensation. (Paper read by Dr. David L. Edsall.)

The Function of the Hospital in Preventive Medicine. (Paper read by Dr. Matthewson and discussed by Drs. Edward M. Brush and Bloomer and Mr. Borden.)

National Insurance Act as it Affects Voluntary Hospitals and the Medical Profession of Great Britain. (Paper partially read by Dr. Boyce and motion made that it be printed in the proceedings.)

Report of Committee on Hospital Administration was read by Dr. Babcock and accepted.

**THURSDAY—EVENING SESSION.**

The Place of a Social Service Department in a Medical Institution. (Paper read by Dr. Andrew R. Warner and discussed by Mr. Borden.)

Social Service in the Out-Patient Department. (Paper read by Miss Elizabeth V. H. Richards and discussed by Miss Cannon, Dr. Babcock and the President.)

Social Service in the Wards of a General Hospital. (Paper read by Miss Glenn and discussed by the President, Dr. Holt, Dr. Howard, Miss Cannon and Dr. Hurd.)

What Social Service can do for the Clinical Physician, (Paper read by Dr. Roger I. Lee and discussed by Mr. Davis, Miss Cannon, Dr. Prest, Dr. Fowler, Mr. Borden and Mrs. Lewis.)

**FRIDAY, AUGUST 29—MORNING SESSION.**

Dr. Washburn presiding.

Report of the Committee on Bureau of Hospital Information was read by Dr. Hurd and adopted.

Report of Executive Committee on Question of Incorporation was read by Dr. Howland and accepted.

Report of Committee on Hospital Finances was read by Dr. Mann and discussed by Dr. Howland, the President, Dr. Peters, Dr. Drew, Mr. Coddington, Dr. Souder, Dr. Simons and Dr. Howland.

President-elect Dr. Howell was then introduced to the convention, and questions in the Question Box were taken up for consideration.

On motion of Dr. Boyce a vote of thanks was extended to the management of the hotel for the free use of the meeting room, also to Dr. Holt and members of the Committee on Arrangements, and Miss Goodnow for the Non-Commercial Exhibit.

On motion of Dr. Hurd a vote of thanks was extended to the retiring officers and especially to Dr. J. N. E. Brown for three years' efficient service as Secretary of the Association.

Adjourned.



PROCEEDINGS OF THE FIFTEENTH ANNUAL  
CONFERENCE OF THE AMERICAN  
HOSPITAL ASSOCIATION.

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Held at Boston, Mass., August 26, 27, 28 and 29, 1913.

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TUESDAY, AUGUST 26—MORNING SESSION.

The Convention met at the Copley-Plaza Hotel at 11 a.m., President Frederic A. Washburn in the chair.

PRESIDENT: The fifteenth annual conference of the American Hospital Association will come to order. We will first listen to the invocation by the Rev. Samuel G. Babcock, Suffragan Bishop of Massachusetts.

REVEREND SAMUEL G. BABCOCK: Let us all repeat the Lord's Prayer.

O thou great and wise and merciful God, we thank Thee for life and health and all that makes existence a source of joy and satisfaction. We thank thee for that creative power which is so uniform throughout the whole realm of Nature; for the gift of healing, so that even disease is cured, so that pain is overcome and life is made more beneficent. Bless thy servants who have come together here as representatives of that wonderful profession whose members are pledged to the succor of those who experience disability and infirmity. Thou hast inspired them to achieve great things for the help and blessing of thy children, give them even greater light, fill them with thy wisdom, increase their skill, and may they in all their labor look to thee for strength and wisdom. May they imitate the Supreme Physician of the ages who bore our sickness and infirmity with such unfailing strength as to be the perfect example for all that administer to ills of body and mind. Prosper this organization and may this meeting bring forth increased knowledge, fellowship and help for thy suffering children everywhere. We ask it all in the name of Jesus Christ, our great Physician and our Saviour. Amen.

**PRESIDENT:** The representative of the City of Boston has not yet arrived. I will make my remarks first and hope that he will come shortly.

### **PRESIDENT'S ADDRESS.**

**BY FREDERIC A. WASHBURN, M.D.,**

**Administrator, Massachusetts General Hospital.**

Members of the American Hospital Association, Ladies and Gentlemen:

The President of this Association finds one of his most difficult duties is the preparation of the annual address. My first task when this duty became urgent was to read the messages of my predecessors in office. These addresses have been strong as a rule; they have placed the ideals of hospital administration upon a high plane; they have been worthy of the men who have written them. The topics discussed have been many. Among these I find certain definite recommendations which, as no action has been taken upon them, it is well to again emphasize..

In 1908 Dr. Goldwater was impressed with the fact that the Association was becoming too large and its personnel was too complex to work to the greatest advantage in a single section. This is more true today than it was then. At the present Conference your President and Executive Committee are attempting in a small way to try the experiment of section work. I will ask you to watch and see whether it is a success, and, if it is, to take action so that your next President and Executive Committee may have the authority of the Association for repeating this step and perhaps adding other sections.

Dr. Goldwater also recommended the addition to our membership of Hospital Physicians, Surgeons, Pathologists and Superintendents of Nurses. By the timely suggestion of Mr. Ludlam, our President in 1906, the Association was broadened from a Society of Hospital Superintendents to the American Hospital Association. Can we ever be all that name implies until we admit members of our Staff and Superintendents of Nurses? The hospital problems of the future and of the imme-

diate present cannot be handled by hospital administrators alone; we need the help and close co-operation of our Staffs of Physicians. As that is the case, they can best discuss these problems with us at our conferences as associate members of this body.

If Superintendents of Nurses were associate members, I believe that we should have a better understanding of each other's aims and purposes, and that harmony in the hospital world would be promoted. A training school section may very well be one important part of our annual conference.

Let me make a strong plea for such a change in our Constitution as will again broaden our membership and make us truly the American Hospital Association.

In 1910, Dr. Howard, then your President, made a most important recommendation: He called attention to the fact that hospitals can best be placed upon a high plane and kept there if some system of inspection is adopted. We all need and would profit by friendly criticism by competent authority. Dr. Howard thought that this could best be done by the individual States. He was influenced in this belief by the successful work in this line done in Insane Hospitals by the Massachusetts State Board of Insanity. The objection to doing this work by States is that the effect of comparison is lost. We would wish to compare one large general hospital with another doing substantially the same work, to compare the standards of a hospital in the East with one in the West. During this meeting a definite plan for such inspections will be proposed and the Association will be asked to express its approval or disapproval. To me this scheme of inspection, if it can be worked out under auspices in which we have confidence, promises a most important step in advance. From the statistics gathered we should eventually learn the essentials of a model hospital of each class. Hospitals would soon learn that a low per capita cost is not the first requisite; that high grade modern work needs first rate personnel in all departments; complete system of records; all modern contrivances for scientific research; and a spirit of investigation and teaching. How better can this be brought out than by comparison of hospitals trying to do a similar grade of work? It is of course essential that this should be



done by a person with the requisite hospital knowledge, and in a spirit of the utmost fairness. Hospital trustees would welcome friendly criticism and suggestion and the information that their institution is not in all particulars the acme of perfection would do them no harm. When this plan is proposed, I bespeak for it your careful and best thought and favorable consideration.

I now come to the subject upon which I wish to lay special stress in this my Presidential message to you.

*Good organization the prime requisite for medical and surgical efficiency.*

We have to thank Johns Hopkins for the introduction into this country of paid chiefs of medical and surgical services with continuous duty.

The great professional departments of a large modern hospital should each have a single head with a service uninterrupted except for the necessary vacation. This makes possible an effective planning of the work. These heads of departments, or, when the departments are too numerous, representatives of them, to make a committee of not more than five or six meet with the Superintendent of the hospital and consider the problems of medical and surgical administration and the great questions of the medical and surgical policy of the institution. The Superintendent should be required by the Rules of the Trustees to be present at their meetings also. Here we have an efficient organization. The Superintendent is able to get the advice of the ablest men on the Staff in the many problems where he needs such advice. He is the agent of this small representative body of the Staff, of which he is a member, in carrying out their orders where they properly have jurisdiction. By his presence at Trustees' meetings he is able to clear up many points which are not entirely clear to his Board and to turn their thoughts toward the problems which need their consideration.

Here is an organization which will give us efficiency to meet the great questions which are pressing upon us. Preventive medicine: How can the hospital best help? How co-operate in the prevention of occupational diseases? Social service: How far are we warranted in going? What shall be our attitude toward Work-



men's Compensation and other forms of insurance which affect hospitals? Hospitals are in a peculiarly advantageous position to help eliminate social disease. Clearheaded judgment is required in this. How shall we steer our course so as to best protect the community at the same time that we guard the rights of the individual and retain his confidence? These are a few of the questions.

We Hospital Superintendents need all the aid we can get. The Staff is a better Staff if a small representative committee knows and discusses these hospital problems and advises and acts upon these subjects over which it properly has authority.

In some hospitals there exists jealousy of the Staff by the Superintendent, and jealousy of the Superintendent by the Staff. There will be no better way of doing away with this than by creating an organization which will make Trustees, Staff and Administration pull together for the good of the whole institution. The Chief of a medical or surgical service can no longer give what the modern hospital requires by visiting his patients for an hour or two daily. The hospital should demand that each chief shall devote at least half of each day to its service; that private practice shall be secondary. In this way only can we get the highest efficiency. The ideal chief of service should have youth, yet his judgment must be mature. He must have vigor and enthusiasm. He must be just and generous in recognizing and promoting the efforts of his subordinates. He should be able to plan pieces of investigation for his Staff and stimulate their accomplishment. He should see to it that the expensive "hospital days" are not wasted either by patients waiting the convenience of the surgeon for operation or by unnecessary stay in the hospital from sepsis.

How can we obtain such services of men? Only by paying them adequate salaries. The standard of efficiency of an entirely unpaid medical staff has in many instances been high; but it does not meet the requirements of the present day.

You will perhaps ask me what concern this is of the hospital administrator who is not charged with the treatment of patients. My reply is, that the modern medical administrator of a hospital is not doing his

duty by the community or by his Trustees by simply attending to the housekeeping or by limiting his duties and responsibilities as they have often been limited in the past. By acting with a small Medical Board, he should see to it that nominations to the Trustees of the men to fill vacancies on the Staff are the very best possible, and that when these men are appointed they work for the greatest efficiency of the hospital and not for their personal aggrandizement. The Superintendent of the modern hospital to have the highest efficiency must keep in touch in a general way with the problems and progress of medicine. The Medical Board may make efficiency tests of the work of the various departments, or it may delegate this work to a committee reporting to them. Just as it is well for a hospital to submit to inspection and criticism, so it is of advantage to have the different departments examined. In this way we may stimulate careful productive work and prevent slipshod work.

This committee may, for instance, take the records of a number of cases of a certain sort in one out-patient department and examine them to see if the patients received a thorough examination; if all the laboratory tests were made; how many visits there were; the results of treatment and whether advantage was taken of all the facilities for treatment furnished by the hospital. No harm is done if this committee interests itself in some of the functions of administration. It may well watch the admission of patients in the Out-Patient Department; see if there is unnecessary delay; if applicants are not handled with kindness and good judgment. If these duties are not well performed, no one is more desirous of knowing it than the Superintendent. It hurts none of us to be checked up and be given friendly criticism.

Let us then impress upon our Trustees the necessity of paying adequate salaries to these chiefs of service; for we cannot demand from them the work we need until we are prepared to pay for their time. This does not at all mean that we are to throw away the voluntary work of men who make their living by practising medicine and surgery. Their services are of the greatest value to the hospital, and the hospital work is of the greatest value to them. The community needs

that they should have the experience which only the hospital can give. Inasmuch as the hospital is necessarily secondary to their private practice, they must be content to work under the leadership of those who are paid to make the hospital work their first interest.

My message to the larger hospitals is, then: Give more attention to medical and surgical efficiency and to that end get the right men for chiefs of service and pay them adequately to devote a large measure of time to the hospital.

A word about the small general hospitals: I recognize that much admirable work is done in these institutions. I believe, however, that sometimes too little thought is given to the community need when such a hospital is started. Often a hospital could be erected at a central point which would serve several towns and be able to command better work than could several smaller institutions in the various towns. There is a tendency in some of the smaller hospitals for members of the Staff to attempt surgery for which they have had no adequate training. In some places this has been a crying scandal. Medical associations are now proposing to license surgeons. This will help a great deal, but there must be developed a public sentiment which will make ignorant surgery impossible. A surgeon of small experience must learn that it is no disgrace to admit that a given patient's chances are better in the hands of another man and transfer the invalid to the metropolitan hospital, if feasible.

Well authenticated report comes to me that in some hospitals in certain sections of the country the standards of deportment, decorum, and, in some instances, even decency, are low. The relations of Staff and nurses are altogether too intimate. No hospital with low standards in this particular can ever permanently flourish or do good work. I wonder if this has anything to do with the difficulty of some of these hospitals in getting nurses. To any of you who know that I am justified in making these charges, I leave the answer to this question.

Too many small hospitals are started without adequate provision for their support. The result is a constant struggle and a probable attempt to make the



unfortunate nurse in charge a greater burden than anyone should be asked to carry, both in hours of work and responsibility.

We should all use our influence against the starting of a hospital until it is clearly shown that it is necessary; that the location suggested best meets the need; that there is adequate support in evidence, and that its conduct is in the hands of those whose ideals are high and whose methods are practical.

In 1905, when this Association last met in Boston, I well remember hearing an honored superintendent of long experience urge that meetings should be held once in three years, because all the subjects of interest to hospital superintendents had been pretty thoroughly discussed. This was just before any adequate realization of the expanding work of the modern hospital and the responsibilities of its administrator. In selecting topics for my words to you, I have been embarrassed not by the paucity of interesting subjects, but by their multiplicity.

I thank you for the honor which you have conferred upon me in making me your President, and it is my most sincere wish that this meeting may be productive of benefit to the hospital world.

**PRESIDENT:** I have the honor to introduce Councilman Attridge, who represents the City of Boston.

**MR. JOHN J. ATTRIDGE:** Ladies and Gentlemen,—I come here today as representative of the City of Boston, in the absence of his Honor, the Mayor, to bid you welcome, and I welcome you to a great hospital city. Without any boasting or bragging, I think we can say that in the Fenway of Boston we have today the most magnificent group of hospital buildings possibly in the entire world. We have our Boston City Hospital, of which we are proud, and I see here at this meeting the assistant superintendent of our hospital, Dr. Holt, a man with whom I have had a great deal to do regarding the work of the hospital, and I must today give him some words of praise, as also Dr. McCollom, for the work which they are doing for the city of Boston in our great City Hospital. Of course, when we



praise the superintendent and assistant superintendent we should also praise the trustees who have given their time and labor in order to make that institution a success. We are proud of the fact that a business man of Boston has for more than twenty-five years been president of the Board of Trustees. He has rendered a great public service, he has been indeed a real public servant, and I have reference to one of Boston's honored business men, Mr. A. Schumann.

As I say, Boston is really a hospital city. We are proud of our Massachusetts General Hospital, we are proud of our city hospital, we are proud of the Peter Bent Brigham Hospital, and but a year ago a new hospital was opened here, Mr. Robert Dawson Evans Memorial Building, which is near by our city hospital. We welcome you to a city, not only a hospital city, but a city which is a historic city, and I trust that all will not be work, that there will be some pleasure for all of you. Today the weatherman has been good to your Association, he has been good for the last three weeks to the city of Boston, for we have had delightful weather, and my hope and wish is that in this great hospital city, in this great, I might say, hospitable city, in this great historic city, that you will combine business with pleasure. All of you know that all work and no play makes Jack a dull boy, so that I trust that with your business you will mix some pleasure, and that you will see in our city here the great places of historic interest, for this is the city of the Massacre, this is the city of the Tea Party, this is the city of Old South Church and Faneuil Hall, the cradle of liberty, and as representative of the city I bid you a hearty welcome and I hope and trust that your stay here in our midst will be both profitable and pleasurable to you all.

**PRESIDENT:** Our next business is the report of the Committee on Medical Organization and medical Education. This paper is prepared by Dr. Norton. Dr. Norton is unable to be with us, and his paper will be read by Dr. R. B. Seem, Assistant Superintendent, Johns Hopkins Hospital.

## HOSPITAL ADMINISTRATION AND MEDICAL EDUCATION.

BY RUPERT NORTON, M.D.,

Assistant Superintendent of Johns Hopkins Hospital.

It is somewhat perplexing to discover the fundamental reason why it has taken so long in this country to recognize the value in a close union between a medical school and hospital. We take pride in our rapid advancement along scientific and other lines, and our ability to utilize foreign methods when applicable to home conditions. But at the same time, we have such a supreme confidence that our own ways are invariably the best, that we often overlook or do not appreciate the importance of conditions abroad that would be very helpful to us. Perhaps this is especially true in all questions of education. Until within a comparatively few years, education in this country has not been well organized. There has been lots of it, from the time of the little red school house in the country, but it has lacked system. Our interests and our attention have been devoted rather to other ends which appeared to us of more importance. It seemed so easy to get on in the world without a good education. It is quite needless to mention those by name who were foremost in their various professions, and who rose practically to the top, with nothing more than the most meagre education. You can all recall the names of these leaders in America—and there are many of them—who unfortunately did not have the educational advantages almost any child may get today. Not only is this true of general education, but still more so of professional and technical education; and I believe this explains in part why medical education in this country has been so far behind that in Europe and England.

There are some other causes, however, which have played a part. All over the country, in the early years, medical schools of one sort or another grew up like mushrooms over night. At that time there was a need of more physicians, and it was natural that some of these so-called medical schools should be started by some of the older men. There were no hospitals, and

so all the teaching had to be done from books, except for the apprenticeship which some of the students might get as assistants to their teachers. This, of course, was a bad start for these schools, which as time went on grew worse, until today they are sores where they exist, but happily they are being eliminated. There was an excuse for them in the beginning. There is none for their existence today.

Still another reason for our defective medical schools is the fact that it is only a few years since our eyes opened to their deficiencies. We had been content to go on in the same old ruts, feeling very well satisfied with the results. It is but a short time ago that a leading physician in one of our most important medical centres, said at a meeting there, it was being discussed whether the curriculum should be raised from two years to three, that he saw no reason for this. He had attained his rank in the community with only two years' education! Such an attitude of mind has been very common until recently, and has stood in the way of medical progress.

Considering these difficulties which have stood in the path of medical education in this country, it is not altogether to be wondered at that we have not reached a higher level as yet.

Having sprung from England, that is we, as Americans, being largely of English stock, it would seem quite natural that we should have adopted English methods and customs more than those of other nations, and such is the fact. This is why today our hospitals and their administration are more English than European in type. From Germany we have taken perhaps more than from any other country our spirit of research, but European administration with all its red tape did not, and does not appeal to us. Why then is it that we have been so reluctant to accept the close union that exists in England between medical schools and hospital. How did it happen that the great leaders in American medicine at the beginning of the nineteenth century, who went from Boston, New York, Philadelphia and elsewhere to Edinburgh, London, Paris and other European cities for advanced instruction, failed to note the advantages accruing from the presence of students in the medical wards of the Eng-



lish and Scottish hospitals, and did not on their return try to develop the same or a similar system in the hospitals in this country with which they were connected? I do not know how to explain this, unless it may have been due to the fact that neither hospitals nor medical schools had at that time arrived at such a point of growth in this country as to make such a scheme in any way feasible. The status of general education at that time was in a very undeveloped condition. It was only in its early infancy.

The intimate connection of the school with the hospital has existed in England since the end of the eighteenth century. Have we ever heard any complaints of the system from them? I think never, but at least none of any consequence. The scheme adopted in these hospitals has gone on for years, and generally with mutual satisfaction to the community at large. No medical school in England could exist without some close affiliation with a hospital.

I think none will attempt to deny that no medical school can thrive by itself. This has been abundantly proven and it is not worth while to waste time on this fundamental proposition. Anyone conversant with the problems of medical education will grant this as true.

Starting with this as the basis of our demonstration, let us try to work out some plan by which students may be introduced into the wards of our hospitals without disturbing the equanimity of the hospital superintendent or arousing an antagonistic feeling in the public.

Let me here for an instant digress to express merely an opinion, and that is that today this very topic which I am discussing would not be such a live one were it not for the indirect influence of Dr. Henry M. Hurd. From the time he was chosen superintendent of the Johns Hopkins Hospital and the Medical School was opened, he worked with the sincerest co-operation and the utmost sympathy for the success of the undertaking. He was broad-minded ahead of his times in this respect, in that he saw at once what the value to the Hospital would be in having such a union. Had it not been for him, had some narrow-minded man been Superintendent, the Johns Hopkins Hospital and Medical School would not hold the position they do. When the history



of the development of medical education in this country is written, his name will be classed with those who have done most for its improvement, and in this respect we owe him very great regard, as we should and do willingly in other respects as well.

In the discussion of this subject, I cannot help constantly referring to the Johns Hopkins Hospital, for here first in America was the system of admitting medical students freely to the public wards of a large hospital first adopted. As yet few other hospitals have followed in its footsteps, so that I am limited to it largely for drawing my conclusions.

In this connection I desire to quote a paragraph from the address made by the late Dr. Jonn S. Billings at the opening of the Johns Hopkins Hospital, May 7, 1889, nearly twenty-five years ago. It is as follows:—

“The third principle to be kept in view in such a hospital as this is that it should provide the means of giving medical instruction; for the sake of the sick in the institution as well as those out of it. It is well known to those familiar with the subject that the sick in a hospital where medical instruction is given, receive more constant, careful and thoughtful attention than do those in a hospital where no such instruction is given. The clinical teacher must do his best; keen eyes will note every error of diagnosis, every failure in results of treatment. Moreover, the very art of teaching clarifies and crystallizes his own knowledge; in attempting to explain, the dark places become prominent and demand investigation, and hence it is that those cases which are lectured on receive the best treatment. I will say nothing here on the other side of the question, the value of properly trained physicians to the community and the necessity for hospital instruction in such training.”

Such were the ideas of one of the medical men of broadest vision nearly a quarter of a century ago. How slow the advance has been since then, and how little ready we have shown ourselves to follow these words of wisdom!

At the Johns Hopkins Hospital the new method of training students started under most favorable conditions. The school graduated its first class, and that a small one of only 15, eight years after the hospital was opened. As you see, the hospital was not sud-

denly called up to open its wards to a large graduating class say of fifty or sixty. This might have delayed the success of the undertaking very seriously. This condition is one that has to be met not infrequently now, when hospitals and medical schools are uniting, and while it adds to the difficulties of the proposition, they are not insurmountable.

The first class that graduated from the Johns Hopkins Medical School was a picked group of students, who were at once freely admitted to the wards, of course under the direction of older men. These first graduates and their successors set a standard of conduct which has been lived up to ever since. It has been a case of "noblesse oblige."

Our medical school has grown and the number of our hospital beds has, until this year, remained practically stationary. Besides this, other difficulties in the management of large classes of students have risen and have had to be met. New difficulties will arise in the future, but it will be possible to surmount them, as it has been in the past.

We would not close our doors to medical students under any conditions that can be foreseen, and expect to derive still greater aid from our students in the future than in the past, for with the constant development of medicine along new lines, we need more and more students in our wards to carry out the necessary investigations.

Students are admitted with greater or lesser freedom to all our public wards (lesser in the gynecological and obstetrical wards) and it will not be long before we shall admit them in groups of two or three to study some private cases. I heard Sir William Osler advocate this only recently, and from my observation at The Johns Hopkins Hospital, I can see no reason for not doing so if the patient gives consent.

There are, so far as I can see, only three reasons to oppose the admission of students:—

1. The danger to the patient. I will go on in a moment to explain exactly what I mean by this.

2. They entail an increased burden of expense to the hospital; and

3. They interfere with the smooth running of the cut and dried ward routine and the nursing as it should properly be carried out.

Let us stop for a moment to consider these three objections and see if they are fundamental. I do not think so. What I meant just now, when I spoke of the danger to the patient is this. A hospital is primarily for the care of the sick, the best possible care that can be furnished. Now there is a danger which must be carefully guarded against, and that is that the student may come to look on the patient as merely an individual to be experimented upon. He may forget that the patient has no active interest in some vague scientific problem on which he, the student, may be at work. The patient wants to get well and out of the hospital as quickly as possible with the least annoyance to himself. This is a feeling we all have when we are ill. We even as doctors with real scientific tastes are apt, with rare exceptions, to take little or no interest in our own maladies. We do not want to be bothered with young doctors puncturing our ears, taking our blood pressures, doing venesections on us and making numerous other tests, if it is unnecessary for the diagnosis of our illness. Where students in bodies have to be taught how to make a variety of tests, it does happen that some patients are unnecessarily experimented upon. I do not say that it does them harm, but it annoys them and they do not like it. The resident physician and the ward officer should very carefully control all the work done on patients by students, and see that this does not happen. If a complaint of this nature should come to the ears of the superintendent, he should at once take the matter up with the chief of staff, and see that in future the students exercise more care and judgment. This trouble will arise from time to time, but it is one that is easily adjusted, and the proof that it is not a serious drawback to the presence of students in the wards is that with but few exceptions the patients like the examinations made of them, for they come to feel that more interest is shown in them when the students work over them. If a patient object, leave him alone for a day or two and he will soon want the attention he sees his neighbor getting. In every hospital, whether there are students present or not, there are to be found



patients whom nothing will satisfy. They are chronic fault-finders and it is seldom worth while to keep them, unless they are seriously ill. It is better to discharge them, for they are a bad influence in the ward and a disturbing factor to the other patients. If a student, in spite of cautions given him, persisted in doing things which were recognized as harmful in any way, he should be expelled from the hospital and not allowed to graduate as a medical student. Such a fellow would never be a fit doctor to care for ill people. I have never heard of such an instance, and it is hardly worth while to speak of the possibility, except that it may occur to some of you, who fear the introduction of the student into the hospital.

It is perhaps worth while to state right here that in any instance the admission of students to the hospital wards should be controlled absolutely by the hospital authorities, who should accept as ward officers only such men as have, while studying in the medical school, proven themselves to be of character, high ideals and capable of appreciating both their responsibilities and their opportunities.

We have agreed that no medical student could be properly taught unless he had hospital advantages; therefore you must give him those advantages, no matter what they cost, for you cannot afford—I am willing to go so far as to say that I believe it unmoral—to turn out young men with a doctor's degree to practice on the lives of citizens, who have not had hospital instruction. The medical school should share with the Hospital the extra cost, and if it cannot it should close its doors, for it is not doing right to its students—not giving them what it has promised. I do not see any reason why the hospital should assume the entire additional cost, though it should in part, as it derives real benefit from the students. You who have not had an opportunity to see how a hospital runs with students in its wards, will wonder what these additional expenses are. First and foremost, they are abundant laboratories and work-rooms. This means much larger supplies of all sorts needed in the wards for examination of the patients, blood counters, stains, urine glasses, urinometers, towels, writing paper, etc., etc., and there are doubtless considerable wear and tear which in a cost accounting



system might be properly charged up to the students. In addition to this, there is an increased waste of material, for students have to be taught in the wards the careful use of hospital supplies of all sorts. Few students stop to think of the cost of materials furnished to them, and they are inclined to be extravagant in the use of dressings, and are also thoughtless and hasty. They have to be taught, for example, that bandages need not be cut off, but often can be unwound and used over again after proper cleansing. There are numerous other details which they are unacquainted with when they first come into the wards, and which they only learn by careful oversight of their superior officers and by routine teaching. Even with picked students it is surprising to note how wasteful they are, because they do not stop to think and because they seem to believe that the institution they may be connected with has unlimited means. They are hasty also, and we all remember the adage that "haste makes waste." Then again, in your operating rooms and infectious wards, you must have suits and coats for them, and you must furnish them with lockers for their clothes, microscopes and books. You will find when you start the system that the demands are many and at times heavy, but in one way or another you must meet them and recognize that they are a proper charge on the hospital and school.

But enough in regard to the expenses. Now let us turn to the second point. We shall all agree, I think, in believing that no general hospital, let us say of about 250 beds, can get on without a training school for nurses attached to its organization. As the training of medical students has advanced and grown more complex, so has that of the nurse, and with the constant presence of medical students on the wards it has become almost impossible for the nurse to do all she should, all she is trained in the best schools to do for the care of the sick. Not only is she prevented from carrying out instructions, but she quite easily gets a false idea of the importance of some regulations laid down possibly by the chief of staff himself. Take for example the following case: A typhoid patient with a high temperature. The nurse has been instructed to give him

a cold sponge or bath every three hours when his temperature is over  $102.5^{\circ}$  we will say. The doctor comes to make his rounds at 9 a.m. At 9.30 the nurse should give the patient a bath, but while the rounds are in progress and the chief is talking to his students and listening to a heart or chest, he does not like to be disturbed by the noise accompanying the giving of a tub bath or sponge to the patient in the next bed. The nurse is told to wait until after rounds. Such an occurrence might easily present itself, and naturally a nurse cannot understand why the patient's bath is less important than the rounds. In my opinion the doctor acts wrongly in such a case, and the patient should receive the correct treatment, whatever it is, at the right time. But interruptions of this sort occur constantly where rounds are frequent in a teaching hospital. For the benefit of the patient primarily, and that the nurse may not fail to recognize that her first duty is in caring for the sick, such occurrences should be eliminated as far as possible. They must be carefully guarded against. In the Johns Hopkins Hospital, unfortunately, some of the wards contain both medical and surgical cases, so that rounds may be conducted in them for instance from 9 to 12 noon. This renders it almost impossible for the nursing to be done as it should be in some instances, but in spite of this difficulty we have found it ultimately to the distinct advantage of the patients to have the students in our wards.

You may well ask what is the best arrangement that can be made to make sure the nurses do get the training they should. I would suggest that one day in the week in each ward there be no rounds and the students be admitted to do only the necessary routine work. This would not materially interfere with the training of these men.

What we are all looking for and aiming to reach is the most efficient hospital administration possible. *Efficient* as I understand it means such a hospital administration as does the patients most good, for that must be always our ultimate goal. This goal can only be obtained by the admission of students to the hospital wards, I believe. A hospital can doubtless run much more smoothly if there are no students, but when the impulse of their presence is lacking, the hospital will

jog along, moving without much impetus. It will grow but slowly and its progress will be retarded. Its administration will be inefficient in other words, for not as much will be done for the patients as might be. Keep the welfare of the patient always in mind, and your efficiency will be constantly developing, for all departments are finally run with that end—the welfare of the patient—in view.

You who may be about to unite your hospital with a medical school that has a large body of students, say 60 to 100 in each class, will want to know how to start the work. It is almost unnecessary to say that medical students should not be admitted to the wards to share in the study and care of the patients until the beginning of their fourth year. To take care of such a body of students, it is absolutely necessary that a hospital should be provided with at least 150 to 200 public ward beds, the more the better. These beds should be both medical and surgical, the latter to include gynecological and obstetrical. When the students begin their fourth year, they should be divided into groups to serve in rotation in the different wards. If you have many students and few beds, the task is difficult and ungrateful, for you cannot give them a sufficient number of patients to look after. But with a class of 60 and 200 beds in an active hospital, you can so arrange their work as to give them a most satisfactory service. It is easy to arrange for six or eight students to work in a ward of twenty-four beds. Each student then has three or four cases under his supervision, and if the service is active, he will have all he can attend to while on duty in the ward.

His duties must be very carefully outlined to him by the doctor in charge of the ward, and the latter must see that his orders are conscientiously carried out by the student. It is the student's task to take the history of the patient, examine his urine, make a blood count and take the blood pressure. Any actual physical examination of the patient can only be done with the ward officer present and assisting. No gynecological examination is granted to a student unless by the resident or the chief of staff, and then only in exceptional instances to a single member of the class, never to a group of students, who of course might be allowed



and would naturally in very many instances examine the heart and lungs of a female patient. It is, of course, in the gynecological and obstetrical wards where the greatest care has to be taken not to offend the dignity and modesty of female patients. But even in these wards, under proper supervision, and I desire to emphasize the word *proper*, such special examinations as must be made can be made without any offense by dignified, self-respecting students, when they have received the right sort of training from their teachers. And here I just want to add a word to the effect that many of the faults observed in students are due to the imperfect and oftentimes negligent training of their teachers. The student alone is not at fault, but those also, and more seriously, under whom he has been trained. In this connection also I would like to say that while students are often turned over to the hospital faultily educated, the hospitals are also to blame in not improving their education by failure to supply them with the necessary facilities. If a hospital opens its doors to students, it takes upon itself a large responsibility, and should recognize this and live up to it. The hospital should not use students for its own benefit, as it has done so often in the past with its nurses, whom it has attracted under false pretences, and turned out untrained and incompetent, a real danger to the community. It is the duty then of a hospital, if it enters upon an agreement with a medical school, to train its students, to give them every facility possible that modern medicine demands, and this means one of the large sources of expense in the way of well equipped laboratory facilities of one sort and another.\*

I have merely sketched the organization of a medical clinic in a general hospital. My paper is already a long one, and I do not know that it is worth while here to line it in more detail. The arrangements made must

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\*As Mr. Abraham Flexner said in his report on the medical schools of this country, there are hospitals, so ill-conducted, as not to be suitable for the admission of students, just as there are schools which turn out men so badly taught that no hospital ought to take them in to work in its wards. Both schools and hospitals should work in conjunction and harmony for the common interest of students and patients.



depend in every case primarily on the number of beds available in the hospital and its proper equipment of laboratories, and on the number of students to be trained. They should, I believe not be admitted to the wards as clinical clerks, so called, until the beginning of their fourth year of the present accepted medical curriculum, or at the earliest the last trimester of their third year.

You, as superintendents, will find it important to draw up a few general rules and regulations to guide them in their passage to and from the hospital, for if they are not told what they are and what they are not to do (I do not mean in medical matters, for that must be left to the chiefs of the various staffs and their assistants) you will find them oftentimes a nuisance, over-running the entire hospital.

This system of medical education once started favorably, will rapidly run smoothly and an *esprit de corps* will arise which will help you as much as it does the students, for you will find that you must depend for your own success upon the hearty co-operation of all your internes.

Throwing the hospital wards open to students is not fraught with dangers, only with difficulties which can be met without injury to the best interest of the patients, and that is what you all have most at heart. If you are sympathetic with the scheme, if you can make yourselves see and really believe how valuable it is to all concerned, you will quickly see how helpful it is, not alone to the student, but to the patients, the nurses, and so back to you and the hospital as a broadening, stimulating influence. It will keep you from falling and staying in the ruts of a well organized hospital administration which runs like clockwork, but which has no real spirit of progress in it.

#### DISCUSSION.

DR. J. W. FOWLER (Louisville, Ky.): Mr. President, I rise for the purpose of making a motion, in fact, two. The first motion I desire to make is, that a committee of three be appointed to take up the suggestions made by the President and report them at a later meeting for discussion. The next is that the Secretary—

PRESIDENT: Would it not be well to take up one motion at a time?

DR. FOWLER: They are so closely allied. Your paper is so brilliant and so scholarly that I feel like I am voicing the sentiments of everybody in making a motion that we give you a vote of thanks for this paper, and I will ask the Secretary to put this motion to a vote, that we extend a rising vote of thanks to the President for his paper.

SECRETARY BROWN: You have heard Dr. Fowler's motion. We will take the second motion first, that we thank Dr. Washburn for his paper. All in favor of the motion will please rise to their feet.

The motion was carried unanimously by a rising vote.

PRESIDENT: The motion before the house is that a committee of three be appointed to consider the recommendations of the President's paper and report at a future meeting. Is the motion seconded? The motion is made and seconded, and we now await your pleasure? Is there any discussion?

A MEMBER: At a future conference, or another year?

PRESIDENT: This conference. You have all heard the motion, those in favor signify by saying Aye. Opposed no. It is carried.

We have all grown accustomed to having something interesting come from Johns Hopkins, and we always expect to have a broad hospital policy advocated, and we are not disappointed in Dr. Norton's paper. The paper is now before you for discussion. I have had some personal experience in admitting students to hospital wards and have had nothing but favorable views about it, provided it is done as Dr. Norton insists, under proper regulations. We have done this for a number of years at the Massachusetts General Hospital; I believe it is proper public policy, for the good of the hospital and the good of the community. The Peter Bent Brigham Hospital, which is now open, I think perhaps will pursue this policy, perhaps Dr. Howard will speak on the subject.

DR. HOWARD: Before I say anything on the subject of the paper, Mr. Chairman, may I say this, that we would be pleased to have any members of the convention visit the hospital in the afternoon, immediately after the adjournment of the convention session. Of course, if you come at other times we will do our best to show you about the hospital, but we have arranged to have all our staff there to show you about at that time and those of you who come at that time will probably get better attention. Now, we would like to have any one that cannot visit at that time not to stay away, because we will be glad to give you what attention we can at any time.

As to the using of students in the wards, I thoroughly believe that the time will come when the students will seek all the work that is now done by ward attendants, and I think that the only danger about using students in the ward is that they must be trained to do everything there with the greatest courtesy, that the point of view of the patient should not be lost sight of. If the point of view of the patient is carefully considered and they watch the rights of the patient with sufficient care, I think

that there never will be any trouble about the use of the students in the hospital. I believe it is mutual, that is, it is for the benefit of the patient and for the benefit of the hospital, as well as for the benefit of the students.

DR. WILSON (New York): I believe that the students should have the benefit of the hospital wards. My experience has been that they do get the benefit of the hospital wards in the hospitals over which I have jurisdiction, the Contagious Disease Hospitals of New York. I think we have to take into consideration, however, the danger to the student himself, and I would not say a word about this, and I would not discuss this paper if it had not been for the fact that Dr. Norton says in his paper that he thinks the students should not be allowed in the wards until the fourth year of their course, or in the third semester of the third year, if I understand him right. Three years ago two members of the graduating class of the College of Physicians and Surgeons, of the medical department of Columbia University, contracted scarlet fever, and as a result of this catastrophe failed to get their diplomas in their school year. The medical department of Columbia put over a new rule whereby the students go in in the third year. Now, in order to accommodate all those students in the wards it is necessary for them to begin in the first part of the school year. The classes are so large that we cannot accommodate them all, it would be impossible in our wards to accommodate all the students that we would have to if they came in the last semester, we could not do it, and that is my reason for getting up here now to say that I think that in case of special diseases, contagious diseases anyhow, if they are to be taught in very large number, the instruction must be given them in the first half of the third year. There can be no question about the rights of the students, I do not think there is any question about the rights of the patient being protected at all times. That is what demonstrators are there for. There was also brought out in Dr. Norton's paper the question of having trained men at the heads of medical wards, instead of the visiting physicians. I believe probably I have had as much experience as any other man in the country in that respect, because for all time the wards of the Contagious Diseases Hospitals in New York City have been under trained men, and the medical board has only been subordinate as far as the real direction of the medical work was concerned, to these men. These have been paid men; I do not think they have been paid half enough, still, they have been paid. Now, for the last year we have been trying to do away with paid men—you see we are going back, we are doing just the thing now that this paper said we should not do, we are leaving the direction of the medical work to an unpaid medical board. Up to date it has worked very well, how it is going to work in the future I do not know. Whether or not we can compare a special hospital treating contagious diseases with a general hospital I do not know, but I do know this, that the high paid special help becomes a very big burden upon a hospital, and it is a question in per capita cost of the patients we will have to consider, if we are going to have enough to take care of the cost of running the hospital.



DR. WINFORD H. SMITH: The point was made by Dr. Wilson that there is a difference in wards of the contagious hospitals as compared with those of the general hospitals and this is very true. I do not know just what system of instruction is carried out in contagious hospitals, nor how extensive it is. It occurs to me, however, that there may be this point of difference: That if students are admitted to the wards of contagious hospitals at stated times or periods, this differs somewhat from the system where the students are in hospital wards all day long, doing regular prescribed work, taking the histories, making routine examinations, etc., as part of their training in general medicine and surgery, which is the most valuable experience they can possibly have.

In regard to the added expense of paying the department heads, this is no inconsiderable item, but it seems to me that Dr. Wilson emphasizes too much the per capita cost. Income and expense must always be considered, but it is not, after all, so much per capita cost that we are concerned with as it is hospital efficiency, and hospital efficiency is not per capita cost by any means. It is the thoroughness with which the work is done in every detail; it is the thoroughness with which the patient is cared for from the time of admission until the time of discharge and, in these days of social service, as much longer as seems necessary to insure to the patient the ultimate benefit of the treatment that has been given, or at least begun, in the hospital ward.

There is one point of which I wish to speak a little more fully, and that is medical organization. I trust you will pardon me for speaking of the Johns Hopkins Hospital again, but in order to sketch the organization which at least works well in the supervision of medical students and in the supervision of the work generally, I would call your attention to the organization which we have now found efficient.

We have the regular interne staff, as is customary, which is composed of the recent graduates of the medical school. Graduating in June, they take up their work in September and serve for a period of one year. It is not a rotating service, but a separate service. In other words, if a man elects medicine he stays on medicine for the full year, and the same way with the other services. In addition to the internes or house officers, we have the resident system: A resident physician, surgeon, gynecologist, obstetrician, psychiatrist, and so on, covering each service. The residents are all paid a salary. The term of service is not limited, but may continue for years. We have men in the hospital now who have been on the resident staff for six years. There are also several assistant residents on each service who are subordinate to the resident but above the internes. All work on the wards is under the control of the residents and the assistants.

It is our experience that this system tends to develop another class of men than the usual hospital graduate. It develops men of long experience in clinical work, and men who are more potent factors in forming an organization which exercises proper control and supervision over the ward work. It is a system which



yields very great benefits to the men, to the hospital and most important of all, to the patients.

PRESIDENT: Any further discussion of Dr. Norton's interesting paper?

DR. KAVANAGH: I will simply say that if I were superintendent of Johns Hopkins Hospital I would not care what the per capita cost happened to be. If I were superintendent of the Massachusetts General Hospital I might feel the same way, but most of us have to keep a very close eye on the per capita cost. No doubt this plan is developing a splendid staff of young men. If somehow we could bring about the policy in our hospitals that would develop men along these lines, it would be a decided improvement upon the way we are carrying on our business now. I do not think any of us should be discouraged; we should look after a splendid ideal and long for a million dollar endowment.

DR. CLEVELAND SHUTT (St. Louis): I believe that the essayist has advocated a splendid step in the right direction. He has taken only a small step, however, and I believe he would have been justified in going much further. I believe America will see the day when our hospitals and medical colleges will be combined as one, on the same plot of ground, with buildings under the same management, with dormitories for their students and everything combined in such a way that the administration offices of both institutions will so interlace that the administrative force of each will be very much reduced. I believe we will then graduate physicians who will be physicians by nature as well as by education and that there will be many expenses now incident to the conduct of a hospital that can be reduced, by utilizing not altogether in a medical way the benefits of the close relationship for the medical institution, namely, the hospital site, and in many other ways. The English hospitals are so arranged that the medical student practically lives in the hospital during his entire term of service as a student, namely, for a period of from four to six years, after which time he has the privilege of taking examination and becoming an interne in his own or some other institution. I believe that they conduct those institutions on a basis of economy, and that they get the very best results for their patients, for their nursing staff and for their physicians.

DR. J. W. FOWLER (Louisville, Ky.): I represent a hospital with about three hundred beds. We have quite a large student body from the University of Louisville, and we have not a great deal of difficulty in managing them properly, and it has been said, and I believe it is true, as the essayist believes, that the student body coming into the hospital makes the work of the hospital much more intelligent, awakens all the latent ability of the professor, as he is intent upon teaching to these students what he knows. We admit them all the years of the student's life; we have four years, each year we sell these clinic tickets and admit them into the ward, practically, along, however, with the professors. We never allow the student body to go alone,

and it is absolutely necessary that the superintendent and his assistants pay strict attention that this body does not violate any ethics of the hospital, and in that way we care for those students and have very little difficulty. We expend something like \$10,000 a year in taking care of the university students—an estimated cost of the various materials that they use is approximately that amount, and we believe that it is an excellent investment.

PRESIDENT: Any further discussion? If not, I will call on Dr. Seem to close. I will invite your attention to the afternoon session at 2.30 o'clock in this hall, and also, for the benefit of those who will not be here this afternoon, to the fact that there will be two sessions tomorrow, the Larger Hospital Section at 10.30 a.m. in the Out-Patient Department of the Massachusetts General Hospital, and the Smaller Hospital Section in this room, presided over by Miss Mabel Morrison, Vice-President. The Secretary has some announcements to make.

THE SECRETARY: The President has appointed the following committees: Committee on Time and Place of Next Convention—Dr. R. J. Wilson, of New York, Mr. Asa Bacon, of Chicago, and Miss Riddle, of Newton.

Committee appointed to consider Recommendations in President's message—Dr. J. W. Fowler, Louisville; Dr. Winford Smith, Baltimore; Dr. John M. Peters, of Providence.

The Secretary read a notice inviting delegates to the Floating Hospital.

Adjourned to meet at 2.30 p.m.

**TUESDAY, AUGUST 26—AFTERNOON SESSION.**

**THE RELATION OF HOSPITAL EFFICIENCY TO  
THE EFFICIENT ORGANIZATION  
FOR HOME NURSING.**

BY R. M. BRADLEY, Boston, Mass.

A marked feature of our time is the broader and clearer view that we are getting of the facts with which we have to deal in our community life.

As one result of this, we are beginning to realize that we must work out a properly adjusted general plan for the handling of the whole problem of sickness, whether in or out of our hospitals. In consequence the hospitals are feeling the call that they shall bear a more clearly defined part in this general scheme, partly by doing some of the needed outside work themselves and partly by adjusting their relations to other organizations that have that work in hand.

We are passing the pioneer stage in the problem of handling sickness, when each separate unit had to develop its own individual efficiency, and we are now measuring the efficiency of each unit not alone by its own individual accomplishments, but also by its power of relating its work harmoniously and effectively to the work of other units in the same field. The strong man in the boat must not only be able to put strength into his own oar, but he must also properly adjust that strength to the forces of the other men in the boat. If he does not keep time with the other men his efficiency is at a discount. We are thus coming to test the efficiency of the hospital in part by its ability to help in the co-ordination of all forces for the care of the sick.

We are also beginning to realize that these outside forces, if properly handled and organized, can be made a most important factor in forwarding the hospital's own particular work; and for that end alone the proper organization of these forces is worth the best attention of the hospital head.



It has perhaps been exceptionally hard for those who are giving their life's work to the hospital, fully to realize this relation of their own work to the general field of related work, or to take hold of the idea that this outside work, scattered as it is, is a proper subject for a studied and comprehensive system of organization.

Everyone who is engaged in effective and absorbing work of his own must sometimes find himself forgetting the great general field of which that work is only a part, and there is double danger of this with the hospital. Hospital work is absorbing, concentrating, and closely organized, while the kindred outside work for the sick has been scattered, unorganized, and consequently as a work hidden from the general view. It is therefore difficult to keep in mind its size and importance.

And yet the magnitude of this outside work, when its scattered units are taken into account, is simply bewildering. A recent estimate puts it at ten to one of institutional work. Recent careful canvasses in New York State, covering a population of 17,000, embracing varieties of locations from the East Side of Manhattan to hill townships of scattered farmhouses in Dutchess County, show a ratio of 13.4% of cases of sickness receiving hospital care as against 86.6% cared for at home. The ratio of home cases is undoubtedly far larger in the country at large.

We know that there will be upwards of a million and a half cases of mortal illness within a year in the United States and Canada, and most of us expect, when our time comes, to die at home. There will be more than two million confinement cases, and most of us were born at home and expect to have our children born there. When in addition to births and deaths we consider the innumerable other cases, part of our daily knowledge, of severe illness needing service outside of the hospitals, we get an added realization of the vastness of this problem of the proper care of sickness in the home.

A few years ago I became impressed not only with the amount of work that must necessarily be done, in dealing with sickness, outside of the hospital proper, and within the homes, but also with the amazing lack

of effective organization needed to accomplish that work with any degree of efficiency and economy.

I was not alone in having this impression, for at least one responsible observer has deliberately declared that the net result up to date of organized and scientific care for the sick has been to leave the average family of moderate means, in case of sickness in the homes, worse off as to assistance in sickness other than medical service than it was a generation ago. The well-to-do get the benefit of the scientifically trained nurse, and a part of the population have visiting nurses; but the great bulk of the people are, as regards home care, worse off than a generation ago. This is apparently largely due to lack of organization.

Within the hospital we seem to have everything that organization can do in the way of nursing and care; outside of the hospital conditions are reversed. There is one notable exception; namely, the visiting nurse work. This work, however, is largely identified with the poorer classes, and, at best, meets the needs of only a limited portion of the home cases—those in which there is somebody available to give continuous care to home and patient.

I am not able to give you here more than a brief outline of an attempt that has been made to fill these gaps, and to work out a comprehensive system for dealing with sickness in the home.

The work was started in Brattleboro, Vermont, a manufacturing town of some 8,000 people and a centre for a farming district; the bulk of its population was neither very rich nor very poor, but was pervaded with a strong spirit of personal independence. Their financial and domestic conditions were those of at least five-sixths of the people of the United States and Canada, and their problem was the problem of all other communities. Hospital and visiting nurse services were provided, which did well so far as they went, but served likewise to demonstrate conclusively that a large number of the needs in sickness could not be supplied by such means.

The work of developing a more complete system began, and has continued by taking the case of each family where there is sickness, finding out the exact conditions and needs caused by that sickness in the

household, and studying to supply the necessary service in the best way at the least cost, whatever those needs might be.

To do this it was necessary to have a headquarters open night and day, with a capable person always on hand to take the calls, and then to organize forces in accordance with the needs thus developed.

Now what are those needs?

Dr Richard Cabot and his co-workers have shown us that the patient in the hospital ward or dispensary is not an isolated unit nor a one-dimension proposition; and that, in order to be treated successfully, each case must be considered in relation to the patient's individual circumstances, and must be considered in several aspects besides the purely medical or surgical aspect.

It is hardly necessary to say that the housewife and mother of young children, confined to her bed by either illness or childbirth, is equally far from being a one-dimension proposition or an isolated unit, and that precisely the same principles apply to the treatment of her case, and to many other cases of sickness in the home.

Whether the need be for a highly-trained nurse or for a good plain cook and children's caretaker, or for both, depends upon the circumstances of the individual case, and not upon any fore-ordained rules. Moreover, there is no question that the cook or caretaker may, under certain circumstances, be a more important therapeutic agent than the most highly trained nurse. It is difficult to cure any woman whose household is going to pieces under her eyes, and her actual needs and those of her household must be seen, acknowledged and met.

After work done for a number of years on these lines—work that is still in the experimental stage—the following organization has been evolved:

The headquarters are open day and night to the call of physicians and of families in difficulty through sickness, the usual rules being observed as to relations with physicians in nursing cases.

The working force is as follows:

Under the general superintendent is a visiting nurse doing the usual visiting work, but interchanging and



co-ordinating her work with a supervising graduate nurse.

This supervising nurse has under her a salaried body of non-graduate workers, who work under supervision and direction, doing such nursing work as they are directed and instructed to do by the supervisor, and also such household service as is entailed by the sickness.

In addition to this force there is a directory and employment agency for graduate nurses at one end of the list, and at the other a miscellaneous list of all the people in the town who can go out and help by the hour, day or week. The association does all of its work on a business basis, doing work where necessary, for charitable organizations and individuals, but not dispensing charitable aid itself either in remission of charges or in money.

It is intended by thus organizing to have a capable head in touch with all the forces needed in a household when sickness comes, who can use those forces in the most effective way. In using these forces together, we come naturally to deal with the co-ordination of labor in nursing, a thing which, owing to the newness of trained nursing to the world, has hitherto been strangely lacking in this country. We have had competition where we needed co-ordination.

The ordinary confinement case can perhaps best show the advantage of the co-ordination of graduate with non-graduate service.

When the labor begins we call in the supervising nurse, a graduate thoroughly trained in maternity work, and with the experience of dozens of cases in the course of the year. When she has completed caring for the mother and baby during and after the birth, she leaves an assistant in the house, whose business it is to continue the care of the mother and child under this supervisor's directions, and likewise to help with the meals and with the care of the other children. Where the work is very heavy, a third woman may be needed for an hour or two during the first few days. The case is then carried through the succeeding days by means of regular visits by the supervising nurse, who directs the assistant and gives the case

such skilled work and observation as the conditions call for.

As before stated, I can here only indicate the general nature of this work, but can give details later to anyone who may be interested.

Whether a local unit in this exact form is adapted to larger towns is a matter for experiment to show. What I am sure of is that work in the homes can be fully organized along these or similar lines, and that the co-operation, counsel and assistance of the hospital, which trains women for service in the homes, is needed in order that the hospital may render to the community full measure of efficient service.

So much for the outside organized work in the homes of the people and the relation of the hospital to it.

Now as to the effect of developing and perfecting this outside organization in making the hospital's own main work, within its own walls, more satisfactory and efficient.

It is, in the first place, of the greatest importance that the hospital should get the right patients at the right time. As to getting the right patients, you are all aware that you need vastly more money for hospital construction and management than you have or are likely to get, in order to give accommodation and service to those patients for whom the hospital is the only proper place. If then, you have at your command another plant that, if properly utilized, can properly serve those who do not need to be in the hospital, but are now crowded in to the hospitals to the exclusion of cases that do need your especial facilities, it is an economic waste and a failure in the test of efficiency not to endeavor to make effective use of that plant.

The plant that I refer to is, of course, the home, and in the aggregate it is a far greater plant, and has far greater resources of both money and service than the hospital. It must, however, be used efficiently, and its efficient use has thus a direct bearing on your own effectiveness.

There is another reason why you do not always get the right patient. Without proper organization for the care of the home in emergency, the patient often cannot be spared from the home, or is not spared in time to be helped by the hospital. Here also is an in-

stance of the direct bearing of home care organization on your own effectiveness in doing your own appointed work.

Again, there is no need for me to tell you that timeliness in going to the hospital means much in producing the maximum of benefit from the hospital's services. I need not tell you how greatly this timeliness is facilitated by those outposts in the community, the visiting nurse organizations, for you know it.

What we must not forget is that it is only the edge of a far larger field that is now touched by these visiting nurses, and that the great bulk of cases in the home is still practically out of touch with the scientifically trained nurse.

This same touch by the skilled graduate nurse of the right kind on the wider field that must be occupied by the organizations giving general service in sickness will necessarily produce the same result; namely, getting hold of more cases that need to go to the hospital, and getting hold of more cases in time.

Next, when we have the patient in the hospital and have done for that patient what the hospital can best do, the output of the hospital often does not represent a completed job. The hospital's output is a man or woman who has just passed through a mortal crisis and is usually physically unfit for the stress of everyday life.

Unless the hospital can content itself in many such cases with the empty name of service, or unless an enormously expensive system of convalescent homes is provided (which, by the way, would by no means relieve the patient's solicitude for the home during absence) we must again have recourse to making efficient use of the home. Otherwise the hospital must either retain the patient too long, to the exclusion of other patients, or must turn the patient out with the certainty that there will be a loss of the whole or a large part of the benefit given by the hospital at so great a cost of skill, service and money.

You cannot get the full efficiency out of your hospitals unless by organizing you get the full efficiency out of your homes.

It is an economic paradox to say that there is no money available to save the spending of far more



money. As a business proposition, organized work for the sick in the homes must be made to cover the whole population, if the hospitals are to find room for the cases that should be within their walls, and are properly to dispose of those cases that should not be there.

Outside organization has its bearing upon another field of hospital efficiency; namely, the educational part of its work—the training of women for the care of the sick.

The use of co-ordination of labor by organizations of this kind will afford to the hospitals an opportunity to give a different bent to the minds of those whom they train, and to bring about a change in the present abnormal and unsatisfactory position of the graduate nurse.

We appear to have something like a hundred thousand women doing nursing for a living in Canada and the United States, of whom perhaps ten thousand are graduates of our hospital training schools. What would we think of a West Point or an Annapolis whose graduates had no working relations with the private soldiers, seamen, corporals, sergeants and warrant officers of our army and navy? What would we think of a technical institute whose graduates could not build a bridge or a ship except in association with holders of a diploma? It is hardly an exaggeration to say that by our lack of organization in home work, we have put most of our graduate nurses into a parallel position.

By organizing, we make officers of our trained and educated workers in almost every line of activity, and thus make their skill and education count to the uttermost. Why do we not do the same for our hospital graduates? Instead of this we are making of most of our graduates a body of women with a position so anomalous that both we and they are puzzled as to what to do about it. The public likewise is suffering from this misdirection, and is finding in the graduates of correspondence schools a measure of relief for which they have looked to us in vain. What we shall call for from the training schools in the development of this outside organized work is a woman who can go into any neighborhood, country or city, and become the friend and helper, guide and counsellor of every faithful,

capable worker who is devoting herself to the care of the sick and suffering. Not every nurse is capable of this, but every nurse, when she is getting her training, needs to know that her profession has such ideals for its leaders.

If a well organized, comprehensive system of outside nursing can be established, using co-ordination of labor and making all around service to the home the starting point, may there not be a chance of a better adjustment for the graduate nurse, and a wider field for her ability and proper service? I believe this wider field to be possible, because the proper and effective use of the graduate nurse must in the end be determined by the sickness, not by the pocketbook. Organized home nursing in other countries has produced organized methods of benefit insurance as soon as there is a service to insure for. Organization will doubtless accomplish this with us likewise, not only by reducing the service cost, but by means of insurance, enabling large classes to finance themselves and to get continuous trained nursing when needed, instead of going without or depending upon charity. Social insurance, whether by public or by private enterprise, is a word that we shall hear more of in future years, and there is no escape from the conclusion to which we are coming that reliance on charity to meet sickness and other emergencies of life is not the way out for the classes who are the main support of the country. We can no more serve the needs of those who support us by charity, than we can lift ourselves by our bootstraps.

Again there is a possibility of simplifying another of your problems. Much thought and trouble are being given to the naming and grading of nurses in accordance with varied courses of training. Important as this may be, how can any diploma given months or years before, decide fully the really vital question of how the right woman can be got to the right case? Can this ever be accomplished by the most perfect system of instruction if the products of your educational efforts are turned out with their certificates or diplomas into a weltering chaos to shift for themselves, as they have been for years?

I believe that an able superintendent of a general service office, knowing the individual woman, and

understanding the needs of the individual case, can do more than many diplomas to get the right woman on the right case, provided only that she occupies an independent civic position, where she is bound to serve the public to the best of her ability. Likewise, if she has a real touch upon the homes from which the best nursing material comes, she can do much to get you that material which you need for your training schools.

To summarize, if summarizing is possible with what in itself can be little more than a mere outline:—

Better organized service for the sick in the homes of the independent classes is a necessity.

The hospitals can no longer look only to the work within their walls, but must relate their work in a satisfactory manner with kindred work in the community at large. From them must come help, counsel, and assistance for organizing that outside work.

That work, if organized, will increase by a substantial percentage the efficiency of the hospitals themselves, by helping them get the cases that they should have and to get them in time, and by relieving the hospitals of cases that should be taken home under proper conditions to make room for others in the hospital.

In addition to this, the proper organization of outside work and a better role for the graduate nurse in that outside work, should produce more good material in the training schools, better results from hospital training, and a more satisfactory status in the community for the graduate nurse.

#### DISCUSSION.

PRESIDENT: We will postpone the discussion of this subject until after the next paper and report of the Committee, making one discussion of the whole subject.



## THE GRADING OF NURSES

BY MARY M. RIDDLE,

Newton Hospital, Newton, Mass.

In 1893, just two decades ago, we find there was convened in the city of Chicago a body of philanthropists, reformers and charitable workers having a section devoted to the consideration of hospitals and dispensaries with a subsection on nursing. Their report furnishes most interesting reading and in the light of later-day developments many of the papers and discussions therein contained are truly prophetic.

The same pleas were made that are heard to-day, for we read that "the obligation rests upon the hospital to promote the public health by increasing and diffusing knowledge, and no hospital can be considered as doing its complete best work if it is not contributing to the training of physicians and nurses." And "in considering standards of education for nurses we must not overlook the smaller hospitals for they have their work to do as well as the larger institutions, but that they are in no position to offer adequate teaching experience to a woman who would become a thorough nurse is very evident."

Florence Nightingale (our highest authority) is reported as writing for that convention these words which are among her last written, thus calling for the best,—“May the methods by which every infant, every human being will have the best chance of health—the methods by which every sick person will have the best chance of recovery—be learned and practiced, may we hope that when we are all dead and gone, leaders will arise who have been personally experienced in the hard practical work, the difficulties and joys of organizing, and who will lead far beyond any thing we have done.”

And again she says,—“Nursing proper is therefore to help the patient to live, to teach the nurse how God makes health and how he makes disease, to teach her to observe exactly such stupendous issues as life and death, health and disease, to make her not servile but

loyal to orders and authorities, to teach her how to handle the agencies within our control which restore health and life in strict obedience to the physician's or surgeon's power and knowledge."

The report here quoted from is chiefly historical. It contains the present-day principle and tone asking for better trained people as well as for more and better service to all classes of people, showing that long before the American Hospital Association was born, our forbears and our superiors were making the same demands that are made to-day.

To their everlasting credit be it said that the first calls came from the nurses themselves and they have continued to this moment. This whole subject of the "Grading of Nurses" has its origin in the desire of physicians and nurses, whether organized or unorganized, to secure better nursing service for people of moderate means.

Previous efforts have been futile because they have been made with the idea of securing the best service without rendering an equivalent, or they have been attempts to adapt the best service to the possible equivalent by an adjustment of the time given, or the patient has been compelled to accept the service for which he could render an equivalent without regard to his needs.

These failures prove that people of moderate means are satisfied (and rightly) with nothing short of the best, that when given the best for a shorter period of time, they still remain unsatisfied; while for a longer period of time at the same rate the nurse suffers, thus setting forth anew the old axiomatic principle that you cannot get something for nothing.

In 1892 the Massachusetts Emergency and Hygiene Association undertook the training of attendants with a view to caring for chronic invalids and feeble, elderly people. They chose the name attendant for this class of nurses in order that there might be no confusion with the duties or the place of the trained nurse. In reading their prospectus one is impressed with its wisdom and foresight, for one reads that they were to be duly certified, that the prices for their services were to be limited and were never to be as much as those of the trained nurse, that they were in no sense nurses, but

were to serve where the fully trained nurse was not required.

This movement was looked upon with alarm by nurses in training, as well as by those in the private duty field, but the attendants were never a large number, which was speedily reduced, for they soon laid aside their title and became full-fledged nurses ready to compete for any kind of work. We are not aware of any published reason why their training was discontinued.

In 1895 Miss Diana Kimber wrote a paper for the "Trained Nurse," offering a solution for the two questions, I. "How can we secure more work for our graduates?" and, II. "How can we bring skilled nursing service to people of moderate means?"

The first question was to find its answer in the solution of the second. Miss Kimber proposed a system of visiting and hourly nursing which sounded well and was well for the same class of patients to whom the attendant was suited, but it did not bring skilled nursing service to people of moderate means for the reason that the hourly nurse with her schedule of prices could not earn a living wage. She found that a very sick or an acutely sick patient required so much of her time that she could not visit a sufficient number of patients to make it possible. Moreover, each patient wanted her at the same time and wanted her for the very hardest part of the day's work—proving that nothing short of the best service was sufficient, and it must be rendered at a time wholly suited to the whim of the patient.

Altogether the plan proved impracticable as a remedy for the condition which sought it, though it is now practiced to some extent by nurses who care for chronic patients, and by those who do not seek to entirely provide for themselves by nursing.

The Red Cross Rural Nursing Service ought, and we believe will, assist in the solution of the problem. Its usefulness has not yet been proved, but it ought to reach to the most remote parts of our land and is the logical association upon which to depend.

The Household Nursing Association of Boston, which, to quote from its announcement, "has been formed to fill a need in household nursing hitherto unfilled in Boston—namely, to supply whatever kind of care may



be required for sickness in the home, each kind so graded as to furnish the maximum of efficiency at the minimum of cost, every grade to be under the supervision of a graduate nurse." This service is to include both nursing and housework and will be done by graduate nurses, attendants, and household helpers, according to the needs of the case.

This Association has made some mistakes, but it has also done some good work, though its usefulness can hardly be said to be firmly established. Its intents and purposes are of the best. Whether it can accomplish them is now its question. It has the advantage over most other schemes in that it proposes to do its work on a business basis, as does also the new venture in connection with the Civic Association of one of Boston's suburban towns which proposes to work under the title of "Community Nursing and Mutual Aid Association." Its plans are not altogether formulated, though it will work somewhat according to those of the Household Nursing Association. Its aim is to establish a nursing centre to which those in search of care for their sick will naturally turn. In response they will be given just the kind of care needed. If an attendant is needed she will be sent and will be under the closest supervision from the centre. If a graduate nurse is required *she* will be furnished. Instead of grading the nurses they will practically grade the work and furnish a nurse to fit it.

You can readily see that in practice there is a vast difference and it lies in the fact that by this system, owing to close supervision, the attendant may be superseded by the graduate and vice versa.

The question may be raised that householders will object to so much supervision in their homes, but those who have met the situation say the contrary is a fact among the people we are seeking to serve. It is said the rich people and those having many household servants do object, but that does not concern the nursing centre inasmuch as this class can employ whom they will.

The promoters of this scheme believe that greater good may thus be done for the people they desire to reach than is possible through the establishment of an hospital and bringing the sick to it. At least, they are not making the mistake of instituting the hospital and

demanding new and unethical systems to maintain it, assuming that since they are filling a need, they are justified in securing, for instance, the nursing service without compensation of any kind, depending upon the sensational and seemingly unanswerable affirmation that for the nurse to require such compensation, either in current coin of the realm, or in opportunities for making herself proficient in her chosen calling is treason, because it creates a hardship for said hospital and possibly its sick.

It may be that the proposed scheme for *grading* nurses will result in overcoming the difficulties hitherto encountered, but since human nature does not change upon demand and is much the same regardless of class, and since fixed economic laws far outrank those of the Medes and Persians, and cannot be broken without the destruction of more than themselves, it follows that we must doubt the scheme's ability though we stand ready to extend it a most cordial welcome.

Doubtless some apparent advantages might accrue to the people we most desire to help, but would they be lasting—should we be doing the best for all the people in the long run by inaugurating a system which might eventually diminish the number of good nurses? If the old saw "A chain is as strong as its weakest link" has any truth, then might not our chain be easily broken? True, all people do not *need* high-priced, skilled care, though experience teaches that they are apt to think they do. Besides, who can tell that the patient may not need the best and most intelligent care before he is returned to his place in life, and can we afford the risk incurred by not giving it to him?

We all believe that the great middle class is what the world must depend upon for most everything that is worth while, therefore the world should see to it that they have the best. In this our bounden duty is evident and we cannot in conscience repudiate any plan without serious thought.

Again, the smaller and more poorly equipped, as well as the purely commercial institutions, would have better reasons for their existing training schools, but would they have sufficient interest in our people of moderate means to make their prices to them accord with the service rendered? Doubtless some would. But

there is no evident reason why the nurse should be sacrificed or even exploited in the procedure.

It is easy to understand that special hospitals like those for tuberculosis might be greatly benefited, but they have always been free to adopt a system to meet their needs—let them do so now without lowering the standards for general work, for by lowering the standards might we not further reduce the number of really skilled nurses?

The status of the nurse's calling is somewhat precarious to-day and we cannot afford to make it more so by adopting any scheme which shall make the good, intelligent, refined young woman turn from us as she surely will if we lower our standards.

Given a young woman who, though honest and sincere, lacks breeding, intelligence, initiative or wisdom, and the chances are she cannot be so trained that she shall be as good and useful as if she possessed these qualities, or some of them. Above all, we must have the good women, and thus quiet the criticisms regarding the trained nurse, which are so prevalent and so heartrending to the well bred, conscientious woman who knows that the critics are working a hardship in two directions—they blame the schools for turning out poor nurses, or those who do not meet the requirements, while they make it difficult for the selfsame schools to obtain good women.

We are hearing much about shortage of probationers in our institutions, but there are nurses who, having given thought to existing conditions, are somewhat exercised by the fact that too few of our graduates are willing to care for the sick in their own homes. If a growing condition of this kind exists, is it well to increase it?

Institutions, boards of health, public schools, sanitary commissions, states, cities, and public and private corporations are enticing our graduates into other fields because therein is found congenial work though the returns are apt to be less lucrative. The work is congenial because it gives opportunity for thought and growth and has high standards of admission to it—proving the truth of what was read before this Association last year, viz., that "the general esteem in which a vocation is held, increases in direct ratio with the



educational standards of that vocation." Therefore, we must keep up our standards to keep our places full of good women.

The over-trained nurse being obsolete or unborn or at least non-existent, so far as the knowledge of this writer is concerned, it is difficult to speak of her and anything said would necessarily be merely theory; but the *so-called* over-trained nurse we know, though her title is a misnomer, she is as a rule the product of good practical experience with too little ethical instruction which should have been first impressed upon her at her mother's knee. Having been deprived of that, and lacking the sensitive organization which might enable her to realize her need, she passes through her hospital course and enters upon her career outside where she is known for her energy, general intelligence, practical knowledge, and courage in undertaking the hardest of nurses' tasks, but where she fails, or at least does not come up to the full measure of success, because she cannot always discriminate between her duties and those of the physician, or she cannot see that her duty sometimes lies outside and beyond those prescribed as the nurse's own, or she places too high a value upon *her* services, that is, she is egotistical, or she is wanting in a few or many of those fine qualities which go to make "A woman nobly planned."

She is in no sense the result of over-training, but of under-training, and she proves that the training school cannot always supplement in three years of adult life what should have extended at least from infancy.

She is infinitely better than she would have been without the hospital training and she is a very great argument for keeping up the standards and securing good women.

The short course is dangerous as it is nothing more than a short cut to a competency. Is it right to offer encouragement to such? It has always existed, and almost always (not always, of course) been deplored as well as deplorable. The unsuspecting applicant for admission to a nurses' training school studies the possibilities and advantages of this or that school and finally decides upon one because it has the shorter course and will consequently ensure an earlier return.

In due time she takes her place as a student nurse and also in due time finds she has made a mistake, that it is a short course, or practically no course, because little or no attention is paid to theoretical instruction and the practical work is limited in variety. She regrets her decision but she is told that she has agreed to spend the allotted time and therefore cannot honorably change. Perhaps she discovers her mistake during her probationary period and may save herself if she is sufficiently sophisticated.

This happens over and over again, especially in those hospitals conducted for private gain. We may think we can regulate such conditions by law, but we cannot—we never can.

Let a man or woman have the intrepidity to appear before a legislature and pray for the regulation of such a matter and he or she will at once recognize the impossibility, for the petition will be scorned as "class legislation."

That the grading of nurses would be a distinct advantage to the purely commercial hospital needs no great array of facts for proof. The shorter course furnishes a cheaper method of procuring nursing service, therefore it is adopted. If there were some way of informing would-be nurses of the dangers of these schools, or if they could be induced to make their application through an authoritative body like, for instance, the American Hospital Association, or if training schools could in some way be duly and widely published as regular or irregular, the results would doubtless be less grievous.

An advocate of the grading of nurses says, "We must necessarily have training schools of varied degrees of efficiency, some of which turn out nurses not properly trained." Just here lies the danger, but we rarely see it so frankly expressed. Does this writer really mean that it is right to turn out nurses who are not efficient? Doubtless every training school does it to some extent, but only by accident. It is not a part of the plan. We had thought it was honestly intended that each grade was to represent the best of its kind. The act of knowingly foisting incompetents upon the public is most reprehensible and should be absolutely condemned.

Indeed, moderate language fails to adequately express our contempt for such a system.

A writer upon this subject of "grading nurses" says, "Just as there are various grades of schools from the kindergarten to the university, so will there be various grades of nursing schools."

Alas! there can be no comparison here. The kindergarten pupil hopes to go on to the university and even if he does not, he is not, at the end of his kindergarten career, sent out into the world armed with a certificate of proficiency to deal with great questions of health and disease, life and death.

Moreover, our graded nurse will not long remain in the grade where she is placed. Experience with the good, so called, practical nurse (may her ranks increase) has taught us the truth of this statement. She is good, the public likes her and seeks her services. She soon increases her prices and is no longer available for the middle class. We will not stop to discuss her ethics for up to the present time she has assumed no ethical standards and so she is not to be too harshly censured if she has met requirements all along the way; she has gained experience and increased her ability and she is selling her services to the highest bidder just exactly as the business man is doing everywhere. She is also incidentally depleting the number in her grade and will continue to do so.

However, she would doubtless be the better for more systematic training which should be made to fit her needs as an attendant and should consist largely of instruction in practical work and ethics. There is great danger in half-training and great turth in the old saying about a little learning being dangerous, as may be illustrated by the case of the nurse who, having been told that one-fourth was one-half as much as one-half, therefore four per cent. was one-half as much as two per cent., and she doubled the dose she was giving.

The plan of training as formulated by the Community Nursing Association is to be commended in that it proposes to train its attendants for its needs and to grant no certificate but to be willing to say, "She did our work well and met our requirements, though always under supervision." The same plan would be dangerous in the hands of an hospital because we should



soon see the attendant earning money to support the hospital probably with no cry from the hospital against a three years' course.

There is wisdom in withholding a certificate unless it be granted under certain conditions from the state, and its value when balanced with its danger is exceedingly doubtful in any case. It is too easily flaunted with the idea that I am now equal to the best.

A certificate is not merely a voucher for work well done while gaining a livelihood, but it ought to indicate that the holder has spent time and money in acquiring what it represents; that years were spent previously in laying a foundation upon which to build the ability so represented.

To recapitulate:

We believe the grading of nurses to be impractical because they cannot be kept in grades; that it would be a dangerous system to inaugurate because it would encourage the short-course training school in the purely commercial hospital — thus exploiting the nurses taking the training, lowering the standards, bringing discredit upon the nurses' calling, and reducing the number of good women willing to take up the work.

We believe there is necessity for the attendant, she should be taught and encouraged, but unless she takes a thorough, systematic training she should not be granted a certificate.

We also believe that outside of hospitals of a certain class the necessity for such grading does not exist (at least the necessity has not been demonstrated); that in time the requirements could be met by the Red Cross Rural Nursing Service and such other societies as the Household Nursing Association and the Community Nursing and Mutual Aid Association; that it would be wise to encourage such bodies and quite as easy as to encourage the organization and establishment of hospitals with poor equipment and little money in remote parts of our country, thereby entailing great hardships upon the people it is most desired to help and ultimately resulting, as heretofore described, in lowering nursing standards.

It is also believed that it is within the duty and the province and the power of this great American Hospital Association to hold up the hands of every superin-

tendent of nurses in the land who is striving honestly and selflessly to maintain high standards in her school.

We believe, too, if it can be proved that more good than harm is likely to result from the proposed grading of nurses, that it will be our duty, as it certainly will be our pleasure, to assist in its consummation, for we agree with President Lowell, who said, "We are teaching our people not only that our present patients may have proper care, but that future generations of patients anywhere and everywhere may have it."

We are ready to admit the nurse's responsibility in all matters of public health and common weal.

The thoughtful and accomplished nurse of to-day is studying how she can advance the health of her community and how she can best assist the mothers and sisters and daughters who are caring for their sick in their own homes. She will devote her hours and exhaust her faculties in any scheme that is proposed for their betterment if it can be proved righteous.

**PRESIDENT:** At the last conference of this Association the following resolution was passed:

Resolved, That Charlotte A. Aikens, Ida M. Barrett, Emma A. Anderson, Dr. R. Bruce Smith and Dr. P. E. Truesdale be and are hereby appointed a committee to consider the grading and classification of nurses, with instructions to submit a plan of grading to this Association, for consideration at its next meeting.

#### DISCUSSION.

That Committee will now report through Miss Emma Anderson, Superintendent, New England Baptist Hospital.

**MISS ANDERSON:** The Committee appointed to consider this resolution held its first meeting in Detroit last September, every member being present. The subject of Grading Nurses was discussed very carefully and the general ideas mapped out. The appropriation was not large enough to enable us to hold many meetings; this report had to be printed; and we decided to hold one more meeting only and that numerous conferences by correspondence should be held. The last meeting of the committee was held in Boston the day before the opening of this Convention. A great many members of the Association were approached by correspondence, and the report which is printed and which I hold in my hand, and which I believe has been mailed to every member of the Association, is the result of conferences between the members of the Association and the committee. The committee does not wish to convey the idea that this is at all a definite plan, but we felt that this subject is so vital, and it was really so complex that a beginning ought to be made, and

the majority of the committee submit this report to you today, and the feeling is that the nurses should be standardized. Our idea is to have about three grades of nurses; two grades this Association has already standardized in previous reports. The third grade, women who are nursing with no training except a theoretical one by correspondence schools and women whom doctors have trained in their way, are not standardized. There are various degrees of efficiency among those three, and the fact that nursing is being done, a large proportion of the sick are being cared for by women not of the first grade, graduate nurses from the best hospitals, but are being cared for by special hospitals, such as tuberculosis hospitals, insane hospitals, and by small hospitals not competent to give the full course—these women, this Association has already recognized as in the second grade. It did not seem possible to avoid that third grade of nurses, as they exist, and so many sick people are being cared for by them, this report submits a minimum standard for such nurses, and the committee hopes that this plan will be adopted as a starting point, and that the committee will be continued another year for further study of the question. The difficult part, of course, is the practical working out of this scheme, but there are organizations already existing that are working that out practically, and in another year we shall know something of the results of their work. It seems as though this grading of nurses, judging from the paper you have heard from Mr. Bradley, and Miss Riddle's paper, and the fact that these nurses are nursing without question, certainly is a menace to the sick, and the committee hoped that this report would be adopted and that a full discussion of it today will bring out points that the committee will listen to and be guided by another year, and that those who object to it will state some constructive method by which we may be helped. It is, of course, a simple matter to criticise, but much more difficult to show other ways of doing. The majority of the committee submits to you this report that has been mailed to the members.



## THE GRADING OF NURSES.

### PREFACE.

Extracts from Previous Recommendations of the American Hospital Association.

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### CLASSIFICATION OF HOSPITALS.

- (1) Isolated small hospitals.
- (2) Small hospitals, near to, or in affiliation with large general hospitals.
- (3) Special hospitals, including eye and ear, skin and cancer, children's and infants', lying-in, tuberculosis, orthopedic hospitals, etc. sanatoria for nervous and mental diseases, hospitals for contagious diseases; hospitals for the insane, and hospitals for incurables.
- (4) Large general hospitals.

The Committee recognizes that the training school problem in the isolated small hospital of from twenty-five to seventy-five beds, is a problem apart from the training school situation in larger institutions. Numerically, this is the largest division of hospitals in the classification.

Many of these hospitals have demonstrated the possibility of maintaining training schools that compare favorably with schools in larger institutions. Properly managed training schools in these institutions are recognized as capable of turning out graduates well qualified for general medical and surgical nursing in private families. Many factors entering into the situation of these schools lead the Committee to recommend *a two years three months' course*, of which three months shall constitute a definite preliminary course of study.

The term of school training should be not less than thirty-eight weeks per year for the two years three months' minimum course hereinafter outlined.

**LARGE GENERAL HOSPITALS.** The Committee recommends *a three years' graded course* for training schools

in hospitals of this class, the course to include a probationary period of three months, including the preliminary course, as stated, of from three to six months, for each class of probationers.

The outline for the three years' graded course assumes that hospitals of seventy-five or more beds offer at least, either at home or by affiliation, nursing in the following departments: Medicine, surgery, obstetrics, and diseases of children.

THE TRAINING OF ASSISTANTS OR ATTENDANTS FOR THE  
CARE OF CHRONIC CASES AND THE SICK AMONG  
THE POORER CLASSES.

The following was one of the resolutions which forms the basis of the work of the Committee:

*"Second: To consider to what extent hospitals should undertake to prepare a class of nurse helpers or assistants."*

The inquiries of the Committee have clearly demonstrated the fact that there is a great demand in all parts of the country for a class of attendants or nurses with special training and capacity to nurse or care for patients suffering from minor illnesses, chronic diseases, etc., in the great middle class and among the poorer class. In most of the leading cities a small percentage of the needs of the poorer class are met by Visiting Nurse Associations, Guilds for the Care of the Sick, etc. The number of nurses representing these associations is inadequate to cover thoroughly the field in which they are supposed to work. To meet the demand for this class of nursing a large body of "attendants," with a certain degree of training, is necessary. Their capacity and training should enable them to minister to the class of patients designated above, at a rate ranging from \$8.00 to \$15.00 per week.

The following paragraphs express the views of the Committee:

(a) It is the unanimous opinion of the Committee that general hospitals, meeting the requirements of the two years three months' course, or the three years' full course, are not in a position to train attendants (so-called "nurse helpers").

(b) That nurse "attendants" be trained in hospitals too small to maintain a training school, with a proviso that in these hospitals a sufficient number of graduate nurses be employed to take the full responsibility of the care of the sick and that these pupils act only as assistants to the graduates.

(c) That nurse attendants be trained in the chronic wards of large city or municipal hospitals. It is believed that such a training could be given without interfering with the maintenance of a regular training school, whose special province would be the acute wards of these institutions.

(d) That nurse attendants be trained in hospitals for incurables, homes for the aged and in many of the special hospitals designated in Class III of the Committee's classification.

(e) The Committee would further recommend to the Association that a special committee be appointed to fully investigate the subject of the nursing of people of limited means in their homes, and the education of trained attendants for this work; also to prepare an outline curriculum of training for such attendants and report to the Association at the next annual convention. —From Report of Special Training School Committee, 1909.

\* \* \* \* \*

The Committee appointed to consider the education and training of nurse assistants for the care of people of moderate means in their homes, and the nursing of patients suffering from chronic diseases, reporting to the Association in 1910 expresses its conviction as follows: "The question is not wholly one of nursing service. In many families in moderate circumstances, sickness involves domestic problems, the daily housework and the care of children. With a central organization under practical business management, it should be possible to use to advantage, the graduate nurse, the trained attendant, the experienced nurse, and the necessary domestics. The energies of the more expensive graduate nurse should be largely utilized in teaching her associates the work, educating the families, directing the work of the untrained forces, and in hourly nursing, where this service renders all the necessary help. Where the patient is sufficiently ill to de-



mand the whole time of a graduate nurse, this should be furnished through the acute stages of the disease, and during convalescence or chronic invalidism, the patient may be transferred to the less experienced worker, supervised by the periodical visit of the graduate. In some cases all that is needed in the household is to furnish a cook or laundress and thus release the whole or a part of the mother's time for the care of the patient, under supervision of the graduate nurse, making visits as frequently as may be necessary. The theory would be to utilize the least expensive member of the forces, who can do the work efficiently.

It will be necessary to have a certain number of graduate nurses on salary; perhaps in most communities it would be sufficient to start with one nurse and gradually increase the force as it becomes necessary. Probably the attendants should also be on salary, but the other workers can be called upon as their services are needed, and paid by the day or week as they do their work, or in whatever manner proves to be the most practical. \* \* \* The patients, of course, should pay such portion of the actual expense incurred as they are able to meet. Where it is practicable, without saddling the family with too great a burden, they should pay the balance later as they are able."—From Report of Special Committee, 1910.

## REPORT OF SPECIAL COMMITTEE ON GRADING AND CLASSIFICATION OF NURSES.

### TO THE AMERICAN HOSPITAL ASSOCIATION:

At the fourteenth annual conference of the American Hospital Association, held in Detroit, the following resolution was adopted:

*Resolved, That Charlotte A. Aikens, Ida M. Barrett, Emma A. Anderson, Dr. R. W. Bruce Smith and Dr. P. E. Truesdale be and are hereby appointed a committee to consider the grading and classification of nurses, with instructions to submit a plan of grading to this association, for consideration at its next meeting.*

Section 1. At the same meeting a communication was read from the General Secretary of the Thomas

Thompson Trust of Boston, which has been working for several years to develop a practicable system of caring for the sick in the homes of persons of moderate means. This communication was referred to this committee for reply. It contained the following questions: 1. What is the proper curriculum for the training of "attendants" in small hospitals? 2. Can "experienced nurses" or "attendants" be properly trained outside of a hospital? If so, what is a proper curriculum for such training? As far as possible the questions presented have been replied to, in the recommendations which follow.

The committee held its first meeting in Detroit, Dec. 12th and 13th, with every member present. At the request of the President of the Association, the Secretary, Dr. J. N. E. Brown, attended the three sessions of the committee held at that time. Inasmuch as a considerable amount of preliminary work had been done by the different members of the committee, and as a large amount of information gathered by previous committees was at its disposal, the committee decided to arrange for no other meeting before the issuance of the tentative report for the consideration of the members of the Association, but to meet in Boston one or two days in advance of the fifteenth annual convention, for the final revision or ratification of the report, before its formal presentation before the Association.

As will be seen by the preface to the report the committee availed itself of the labors of the two former committees appointed to deal with the training of nurses, and nursing problems in middle class homes, and endeavored to build on the foundations made in previous recommendations, as far as possible, rather than to make recommendations which might raise again at this time, questions which the Association had previously discussed, and for the present, decided.

Miss Barrett reported regarding her inquiries into methods of classifying nurses in directories conducted by organizations of graduate nurses in various cities. It was learned that in many cities an attempt to classify nurses had been made. The distinctive terms which seemed to be most generally used were graduate or registered nurses, under-graduate, and experienced, or so-called practical nurses. In a few registries, so-called "attendants" are registered, but the term is not com-

monly used by the public, as are the other terms mentioned, neither does it seem to be popular.

Dr. Bruce Smith presented a report on nursing conditions in Ontario, and various parts of Canada, especially in relation to tuberculous hospitals. Reports were presented from various other places, as to how the problem of tuberculosis nursing was being managed in the hospitals and sanatoria of the two countries.

Dr. Truesdale had made quite an extensive investigation into the various methods now carried on of training nurses outside of hospitals. A mass of information along this line has been collected and is available to any who desire it. It can be had by applying to the Secretary of the Association.

## GENERAL CONSIDERATIONS.

*Section 2.* The committee approached its task of making recommendations with the realization that it was dealing with an important sociological problem, which affects hospitals, nurses, physicians, and a large proportion of the people who are doing much of the world's best work, and living on moderate incomes. In framing the recommendations which follow, the members of the committee kept before them the following considerations, which they respectfully urge shall be kept in the foreground in the study and discussion of the report:

(1) That the territory covered by the American Hospital Association extends over a vast area. It includes great stretches of country in which hospitals are far apart, whole states and provinces in which most of the hospitals are small, yet doing a work that is exceedingly valuable to the various communities. It also includes many important medical centres where hospitals and other philanthropies are numerous, and constantly on the increase.

(2) That in many communities in the west, southwest and south, in which public spirit and philanthropic institutions are not as fully developed as in the eastern and central sections of America, privately owned hospitals have developed, and are now developing rapidly to meet the needs of the community, not met by municipal or philanthropic organizations.



(3) That the rapid increase in tuberculosis hospitals within recent years has created a problem in nursing which a decade ago did not exist, and that this problem is certain to increase as such hospitals multiply.

(4) That information gleaned from a great variety of sources goes to show what is undoubtedly true, that, numerous as are the admissions to hospitals, the sick thus admitted represent but a small fraction of the sick which have to be cared for. Apart from surgical patients, the vast majority of the sick, especially obstetrical and medical patients, and chronic invalids are cared for in the home. Statistics presented recently before the Academy of Medicine, New York, stated that ninety per cent. of those who are now doing nursing in America have had no hospital training.

(5) That the large number of newer openings for graduate nurses in social service, welfare work, public health work, and various other lines of philanthropy, combined with the increased demands for institutional nurses, have reduced considerably the number of nurses who would otherwise be available for nursing in homes.

(6) That there is a large part of the population in all states and provinces which is unable financially to meet the expense of a graduate nurse at regular rates, even if sufficient graduate nurses were available to meet the demand.

(7) That the testimony of a large body of physicians, social workers, and interested workers for human betterment, goes to show that the needs in sickness in middle class homes are not always best met by a highly skilled graduate nurse, but that a less expensive worker who can combine ordinary care of the sick with the care of home, is often more desirable both from the standpoint of economy and efficiency.

(8) That there is a large gap in most communities not now filled by hospital service, visiting nursing or by private nursing as at present organized and conducted.

(9) That owing to lack of organization, large numbers of patients, who are necessarily cared for at home, but who are acutely ill, and should have the most skilled care, are not able to secure it, because of the absence of any responsible, representative, organized body of people, to study the needs of such patients and homes,

and help meet their problems. This condition leaves the field free to be exploited by all sorts and conditions of commercial organizations.

(10) That the promotion of economy and efficiency in the home care of the sick is inseparably bound up with the problem of the grading of nurses, their organization and supervision, and has a most important bearing on hospitals and hospital development.

### A SURVEY OF THE FIELD.

*Section 3.* A general survey of the field shows the following groups or classes of nurses at work in the nursing field in the United States and Canada.

Regularly trained hospital graduates who have met the requirements or recommendations of the American Hospital Association for general training.

Graduates of hospitals for the insane.

Nurses trained in special hospitals, such as tuberculosis, maternity, infants, eye and ear, orthopedic, hospitals and homes for chronic and incurable patients, etc.

Partially trained nurses from general hospitals.

Nurses who have been in attendance at schools giving theoretical courses, with arrangement whereby experience is gained under supervision by nursing in private homes.

Nurses who have received their theoretical instruction by correspondence through commercial schools.

Nurses who have had class instruction under the auspices of a philanthropic organization, without provision for gaining experience under supervision.

Experienced or practical nurses, so called, or those who have spent no prescribed time in training, or who have pursued no definite course of study.

### CLASSIFICATION OF NURSES.

*Section 4.* In the beginning the task of classifying and reducing the number of these varied groups, and defining standards of instruction, the committee agreed on the following main premises:

*First*, that the good of the public should be the paramount consideration.

*Second, That the system of grading recommended should be such as to include every one who nurses for hire.*

*Third, That all who nurse for hire should, for the protection of the public, and for the sake of the welfare of the sick, be required to prepare themselves for such work, by a minimum course of instruction and study of the elementary principles of nursing, and that the co-operation of the medical profession and public health officers toward the attainment of this object should be sought for and secured as far as possible.*

*Fourth, That the system recommended must include provision for supervision by some responsible representative local organization.*

Before deciding to submit the recommendations which follow in regard to classification, the committee consulted a large number of hospital superintendents, teachers of nurses, physicians, nurses and laymen, and carefully weighed the various distinctive or qualifying terms which have been suggested, or are in use such as undergraduate nurse, experienced nurse, practical nurse, licensed nurse, attendant, etc. The following considerations carried most weight when the decision had to be made:

(1) Standard dictionaries define a nurse as "a person who cares for the sick, helpless, or infirm." This definition has been accepted and universally used, without question, for centuries.

(2) The person who does nursing, or gives personal care to the sick as an occupation, will be called a *nurse*, by physician, patient, and the public, irrespective of the quality of the work, or of any contrary recommendations which this Association might make, or any other measures which might be used to prevent the free use of the term "Nurse."

(3) Even where a course for "trained attendants" has been offered and given, the worker thus trained, when she enters the home is usually called "Nurse." To insist or recommend that she call herself "attendant" or any other term, when doctor and patient call her "Nurse," can only lead to embarrassment, and to forcing the worker into a false position. It will ultimately help to defeat the objects which it is most desired to accomplish.



(4) Any attempt to restrict the use of the term "Nurse" to registered nurses, or highly skilled graduates, or nurses of registered training schools or hospitals and to prohibit its use by all others engaged in caring for the sick, cannot fail to lead to the embarrassment of a large number of small and special hospitals, and to add to the difficulties under which their work for the community is carried on.

(5) The same arguments against the application of the term "Nurse" to any but highly trained workers, could be used in connection with numerous other occupations, such as teacher, doctor, professor, cook, stenographer, etc. The public will not tolerate such restrictions in its use of the English language.

After prolonged discussion it was decided to recommend the classification of all in the various groups mentioned in section 3, into three divisions or groups to be known as Grades A, B, and C. The terms Registered or Graduate Nurse, Certified Nurse and Household Nurse, to correspond to the different grades, were decided on after long consideration of every qualifying term which has been used in America, of which the committee had knowledge. So far as it was possible to discover, the term "Certified Nurse," originated with the Albany Guild for the Care of the Sick, some years ago, and is used to designate a nurse who has had sufficient technical training to make her safe and useful in ordinary cases of illness, but who does not wish to be known as a fully trained graduate nurse. It is still used by that organization to distinguish the partially or home-trained nurses from the fully trained hospital graduates employed by that association. It has also been adopted by other organizations, to designate a nurse who has had a prescribed course of instruction under supervision, but is not, and does not wish to be known as a fully trained graduate nurse.

The term "Household Nurse" explains itself, and signifies a nurse who, besides assisting in the care of the sick, assists also with the care of the home, in which there is sickness.

*Grade A.—Registered or Graduate Nurses.* This grade shall include regularly trained hospital graduates who have met the requirements recommended by the American Hospital Association, or who are registered

or eligible for registration, in such states and provinces as provide for registration.

*Grade B.—Certified Nurses.* This grade shall include those who have taken courses of training of not less than one year in special hospitals, or in hospitals which are unable to comply with the standards for complete training fixed by the American Hospital Association in 1909, or who are for other reasons unable to meet the requirements for Grade A, but who have had not less than one year of hospital training.

It shall also include those who have met the theoretical requirements for this grade, and have acquired experience under proper supervision in private homes, for a period of not less than one year and four months, or sixty-eight weeks, during which time not less than twenty different patients have been cared for, including medical and maternity patients.

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NOTE.—Fuller details regarding supervision and regulations relating to the group are under consideration, and remain to be worked out more definitely, before further recommendations are made on this point.

*Grade C.—Household Nurses.* This grade shall include all nursing for hire who are not eligible for, and not included in either of the other classes or groups, those who have taken short courses by class instruction or secured private tuition, and also the very large group of workers who have had no prescribed training, who have been pressed into this form of service, by physicians, in order to meet the great demand for this class of helpers. (Note.—The term "*attendant nurse*" is suggested as a possible substitute, if preferred.)

## Section 5. REQUIREMENTS AND SUGGESTED CURRICULUM FOR CERTIFIED NURSES.

### GRADE B.

Many considerations led the committee to recommend as a curriculum for Certified Nurses, the first year course of studies and training recommended by the Special Committee in 1909, with the addition of some instruction in maternity nursing. Chief among these considerations were the following:

(1) The studies outlined should be the foundation studies for either general or special nursing.

(2) The desirability of making it possible for many small and special hospitals which are unable to give a complete training according to the standards of the association, to give a training which would be recognized as a part of the general plan—a preliminary course or primary training, which might be completed in some other larger institution, or one handling a different class of patients. While under present conditions each institution has its own policy, as regards students from other schools, and controls or should control its own admission to its training school, the committee believes that there are ambitious young women who might for various reasons enter first for the Grade B course only, who should be encouraged to continue and later enter Grade A, and that many advantages might accrue from such a policy. Inasmuch as some hospitals now give credit for time spent in pursuing *theoretical* studies in nursing in a school or college, so it is believed that credit should be allowed a nurse who has completed in a small (under 25 beds) or special hospital, the first year course recommended by the Association. It is expected, of course, that the acceptance or rejection of this suggestion would be a purely optional matter with every school, and that credits would be allowed only after an examination, and after the presentation of suitable testimony as to general standing and efficiency, from the school first entered. The nurse who entered for training near to middle life would probably choose to begin to earn from her nursing on completion of the course for certified nurses. The younger nurse with ambition to excel, would probably wish to continue her course elsewhere, and should not be debarred from so doing.

It is believed also that, for home nursing, many valuable lessons may be learned by nursing in private homes, which are not possible to be learned in even the best appointed hospitals, and that adaptability to present-day conditions and needs is more essential to success in this line of work than elaborate surgical technique. The committee wishes to call attention to the fact that the Albany Guild for the Care of the Sick has succeeded in training nurses under its auspices in



homes, and in connection with the Guild headquarters, under the supervision of visiting graduate nurse instructors, who have passed satisfactory examinations and are now registered nurses in New York state, according to the year-book of that association.

For these and other reasons, the committee has been led to suggest one year and four months, or sixty-eight weeks, and the satisfactory completion of the theoretical course for certified nurses, as an equivalent for one year of hospital training. It is the conviction of the committee that the promotion of better nursing in middle class homes demands a recognition of the possibilities of training which are outside of regularly organized hospitals—possibilities which have heretofore been little considered except by commercial organizations.

#### RECOMMENDATIONS FOR CLASS INSTRUCTION.

Ethics and etiquette of the sick room .....	2 hours
Anatomy and physiology ... ..	10 hours
Personal hygiene . . . . .	2 hours
General hygiene . . . . .	2 hours
Bacteriology—theory . . . . .	3 hours
Sterilization and disinfection . . . . .	1 hour
Medicines and materia medica . . . . .	6 hours
Dietetics—theory . . . . .	6 hours
Practical lessons in invalid cookery and administration of food .....	6 hours
General bedside nursing .....	20 hours
Fever nursing, including contagious and care of special medical cases .....	5 hours
Maternity nursing . . . . .	10 hours
Care of infants . . . . .	2 hours
Minor operations and accidents in the home with after care .....	2 hours

It is recommended, for hospitals giving this course, that pupils be admitted for training as far as possible between the months of March and September, so that systematic class instruction may be carried on throughout the school year, and that the annual school term recommended by the American Hospital Association in 1909 of thirty-eight weeks, with not less than two class periods weekly, be accepted for this grade. The com-

mittee makes no recommendation as to whether the probation term shall or shall not be included in the year.

Experience having clearly proven that instruction by the lecture method is liable to vary in contents and emphasis with each individual lecturer, and that inexperienced workers or students are unable to grasp the substance of instruction by lecture, in most instances, the committee wishes to especially urge that standard textbooks be required to be used by all students and teachers, inasmuch as textbooks suitable for each grade are easily obtained.

### SUGGESTIONS FOR BEDSIDE INSTRUCTION.

The list of clinics and demonstrations which follow are those recommended for the first year's training by the American Hospital Association in 1909. It is not suggested that these lessons or demonstrations must necessarily be separated from the lessons on general nursing, nor that they shall be taken in the order in which they read, but that they should be included in the class work and bedside teaching during the year, it being considered that, of all teaching, the practical bedside teaching is the most important.

(1) Beds; bedding; bed-making, with and without patient; management of helpless patients; changing beds; bed-making for operative patients; rubber cushions; bed rests; cradles; arrangement of pillows, etc.; substitutes for hospital appliances.

(2) Sweeping; dusting; preparing room for patient; disinfection of bedding; furniture, etc.; care of patient's clothing in wards and private rooms; disinfection of infected clothing.

(3) Care of linen rooms; refrigerators; bath rooms and appliances; sinks; hoppers; bath-tubs, etc.

(4) Baths—full sponge, to reduce temperatures; foot baths; vapor baths; hot and cold packs.

(5) Administration of rectal injections, for laxative, nutritive, stimulating, astringent purposes; care of appliances; disinfection of excreta.

(6) Vaginal douches; methods of sterilizing appliances; use and care of catheters; vesical douches; rectal and colonic irrigations.

(7) Local hot and cold applications; making of poultices, fomentations, compresses; methods of application; care of hot water bottles; uses and care of ice caps and coils.

(8) Chart keeping; methods of recording bedside observations.

(9) Making of bandages—roller, many-tailed, plaster, abdominal, breast, pneumonia jackets.

(10) Methods of applying roller bandages.

(11) Methods of applying other bandages.

(12) Appliances to prepare for ward examinations and dressings; sterilization of ward instruments; nurses' duties during dressings.

(13) Preparation of patients for operation; hand disinfection.

(14) Preparation and care of surgical dressings, sponges, swabs, etc.

(15) Tray setting and food serving; feeding of helpless and delirious patients; management of liquid diet.

(16) Administration of medicines; methods of giving pills, tablets, capsules, powders, oils, fluids; application of plasters, ointments, etc.; use and care of medicine droppers and minim glasses, atomizers, inhalers, hypodermic syringes, etc.; management of inhalations, eye drops, suppositories, etc.

(17) Care of the dead.

(18) Symptomatology—the pulse; correct methods of examining pulse; volume, tension, rhythm, rate, etc.; effect of exercise, emotions, baths, drugs, shock and hemorrhage.

(19) The face in disease—the skin; expression, eyes, mouth, teeth, etc.; variations from normal, care of mouth and teeth; general observations of the body.

(20) Respiration—normal, and in respiratory affections.

(21) Pneumonia—respiration, cough and sputum; crisis and lysis explained and charts shown.

(22) Typhoid fever—face, rose spots, temperature charts, changes in temperature and pulse explained; danger signals; prophylactic measures; methods of managing delirious patients, proper restraint, etc.

(23) Specimens of excreta—urine, sputum, fæces, etc.; nurses' duties regarding each; importance and general management.



It is assumed that, in special hospitals, instruction in the management of the special class of patients treated in each special hospital will be given in addition to the studies outlined.

It is further recommended that institutions or organizations offering this course, do not advertise to give *diplomas* in nursing, but do distinctly state that only the *first stage of the full nursing course is offered* by the school; also that the certificate given should clearly state that the candidate has completed *the prescribed course for Certified Nurses and the duration of the course*. It is the conviction of the committee that the first step to a proper distinction in the minds of the public between a nurse who has had a complete training and one who has had a partial, though distinct training, is for hospitals themselves and hospital staffs to clearly observe such distinctions, and to recognize their own limitations.

## REQUIREMENTS AND SUGGESTED INSTRUCTION FOR HOUSEHOLD NURSES.

### GRADE C.

This grade must be recognized as the beginner's grade. It includes the largest number of all the groups in the nursing field, and the most difficult to grade and manage. Investigation and observation have shown that physicians are constantly finding in their practice excellent women who show some fitness and aptitude for nursing, yet for various reasons are debarred from taking a full course of training. Many physicians have testified that they would gladly insist that these helpers in the sick room pursue a minimum course of instruction, if local facilities were afforded, and if they could secure such instruction without too great expense and loss of time. This group more than any other is exploited by correspondence schools, and many in this group are led to believe that they can, *through correspondence*, secure a standing and training as a nurse, equal to that of the hospital graduate, and that the course of instruction offered by correspondence is superior to that given in hospitals. The prices charged each worker for such instruction range from \$50 to \$100 and upwards.

The committee after careful study of this phase of the problem has been led to recommend that a minimum course of four months be offered by local organizations, covering chiefly the methods to be used in common nursing duties, believing that more will be effected in the direction of improvement in household nursing, by placing the *minimum* standard of instruction so low that any one fitted for such work can secure it, than by placing it so high as to be discouraging to this large group of workers. The committee wishes to emphasize that this standard is *a beginning*, and to remind the Association that in the beginning of trained nursing, a one-year course in a hospital was considered a complete training, and that the instruction prescribed and recognized as a complete training at that time was substantially that which is here suggested for household nurses. It is hoped, as physicians begin to realize the value of even a minimum course, that the standard can be raised. A great many workers in this group, after completing the beginners' course, should be encouraged to continue their study and efforts to improve, and to qualify as certified nurses.

#### PERSONAL REQUIREMENTS FOR NURSES IN GRADE C.

A certificate of health.

High moral character.

Sufficient education to read and write and keep intelligent notes of cases.

Recommendations from not less than two responsible citizens (not relatives) one of whom shall be a clergyman.

#### SUGGESTIONS FOR INSTRUCTION.

Etiquette and ethics of the sick room, 2 class periods.  
Germ theory and principles of asepsis, 3.

Methods of sterilization and disinfection of everyday sick room utensils, 1.

Household hygiene and management of sick room, 1.

Personal hygiene with special reference to avoidance of infection, 3.

Care of bed, bed-making, bed-sores, etc., 1.

Making the best of household materials in sickness, 1.

Personal everyday care of sick, 1.

Special methods of promoting the patient's comfort, 1.

Feeding the sick, 2.

Invalid cookery, 4.

Temperature, pulse and respiration, 2.

Observation of patients and note-taking, 2.

Baths, cleansing, and to reduce fever, 1.

Home treatment—packs, hot and cold; enemata; douches, poultices; cold compresses, hot fomentations; sweat baths; catheterization; care of ice caps, hot water bottles, etc., 4.

The giving of medicines, 2.

Care and feeding of infants, 2.

Care of sick children, 2.

Common household disinfectants—how to make and use them; precautions, 1.

Practical points on dealing with communicable diseases in the home, 1.

Bandaging, 1.

Household emergencies and minor wounds, 2.

Maternity nursing, 6.

Special medical cases and care of chronic invalids, 4.

NOTE.—It is suggested that lesson periods be not less than one and one-half hours, and that practical demonstration of correct sick room methods be included, whenever possible, in every lesson.

## *Section 6. ORGANIZATION AND GENERAL CONTROL.*

The question of state control of all grades of nursing, versus general supervision and control of Grades B and C by responsible representative organizations operating in a city or county unit, with the probable co-operation of local public health officers, has been carefully considered by the committee, and the advice secured of a large number of interested physicians and others who have had much experience with the problems, successes, and failures of state control along other lines. It is the consensus of opinion that any attempt at state control which is not preceded by a widespread and protracted campaign of general education and organization, would retard rather than promote the improvements desired; and that at present much greater possibilities lie in developing local Household Nursing Organizations, which will work out the many problems which should be worked out before intelligent legislation is possible.



The committee desires to call the attention of the American Hospital Association to the plans for the care of the sick which are outlined by the newly-organized Bureau for Organizing Home Care for Sick\* which exists to assist in the promotion of local organizations for neighborhood co-operation in the general care of sickness in the home. A considerable part of the work of this bureau will consist of investigation and research such as is now going on in several places. A fundamental feature of its work is to start with the home, studying its needs on the case system, and organizing its work and shaping its plans in accordance with the findings. The plans on which such work may be conducted have been given practical test, first in Brattleboro, Vermont, and have been adopted wholly or in part by organizations doing similar work in Boston and elsewhere in New England. The methods that have been evolved by an experiment extending over several years, seem to be equally applicable to large and small communities. The object of a local association of this character may be briefly stated to be "to do what is possible to supply those needs in sickness that are not now properly covered by hospital service, by visiting nurses, or by unorganized private nursing." It aims "to become a medium of exchange between those who need help and those who can give help in sickness or emergency, and to serve the growing needs of the community."

The plans include the establishment of a Household Nursing Office which will serve as a centre for a given territory and a clearing house for several grades and kinds of workers, who should be provided to meet a need in time of sickness in middle class homes. Such an organization does not attempt to dispense charity, but does attempt to furnish at cost such service as is needed. It aims to furnish, where necessary, a graduate nurse for service through the acute stage of a disease, to replace her by a less skilled worker, when highly skilled care is no longer needed, so that the valuable services of the fully trained nurse may be more generally utilized where highly skilled nursing is

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\*The Bureau for Organizing Home Care for the Sick has its present headquarters at 60 State St., Boston.

needed, but is not wasted where others less skilled will fully meet the needs.

The office is managed on a business basis, and is in charge of a graduate nurse, who provides for the supervision of such household nurses and other helpers as are needed in sickness. The office has on its lists, names and addresses of persons who are free to go to a home and serve by the week, those who can serve for a day or part of a day, those who do cooking or washing, or are able to care for children, and various other classes of helpers who are able to fill gaps in homes in which sickness has entered. It does not find the money to pay these workers, but endeavors to furnish them at rates which the family or friends can meet.

The putting into practice of such a plan involves a number of questions which require the most careful consideration, in order to reach a proper solution. Your committee suggests, therefore, that the best method of promoting a wise and proper plan of organization, is to develop as soon as practicable a few more centres which will serve as experiment stations, under the best possible expert advice, both for the nursing and medical side and for the sociological and business side. This would make possible the increase of practical knowledge with which to solve doubtful questions, and would establish as soon as possible sound, practical, working standards relating to this particular department of humanitarian work.

Experience gained in the household nursing centres which have been developed goes to show that under a proper business-like plan of organization for the care of the sick in the home, it is possible to provide a skilled graduate nurse for supervisory, educational, and emergency work, and the services of a household nurse for continuous nursing in homes, at a cost of from \$8 to \$16 weekly. In maternity nursing in the home, this sum includes pre-natal care and supervision, the services of a graduate nurse to assist at the birth and for the first nursing care of mother and baby; daily calls from the graduate nurse as long as necessary, and the continuous service of a household nurse, who receives bedside instruction from the graduate nurse. In Brattleboro, Vermont, the average cost for two weeks of this service,

in twenty-five routine cases which were averaged, was stated to be about \$12 per week in 1911.

The organization needed to provide such service does not differ materially from the organization for a small hospital, where a representative board is in general control, a skilled graduate nurse is in charge of the hospital and of the details of the work, and where the nursing in the hospital is done, for the most part, by pupil nurses, with graduate nurses for the places requiring special skill and experience.

It is the belief of the committee that intelligent expansion of hospital and nursing service in any community, and also the promotion of economy and efficiency in hospital management, demand that a broad statesmanlike view be taken of the entire problem relating to the care of the sick; that a careful study be made of the existing facilities for meeting present-day needs, and of other facilities which should be brought into existence in order to adequately and efficiently and economically care for all classes of sick in the different communities; also that some definite plans for co-operation in administration be worked out by the various organizations devoted to the care of the sick. Such questions as, "Who should go to a hospital?" "Who should be cared for at home?" and "How to provide the most efficient care in each case?" so that the best results to the individual, the family and home and community, may be obtained, are large questions which cannot be decided satisfactorily by any one group of workers, but which require the combined wisdom of several classes of workers in the field of philanthropy. Whether it is wise to ask for public funds or private capital to provide hospital accommodation for patients who could be as efficiently and safely cared for at home as in a hospital, and for the same rates or less, given reasonable provision for meeting the needs of the patient and home, is an important and unsettled question relating to hospital and home economics, which has a definite bearing on the grading and organization of nurses, on how many kinds of nurses should be trained, and how they should be trained. These questions suggest the magnitude and complexity of the problem of the development of nursing facilities in relation to the needs of



each community, and of the responsibilities of hospitals in connection with the problem.

### *Section 7. CO-OPERATION WITH PHYSICIANS AND PUBLIC HEALTH OFFICERS.*

While it is the hope of the committee and of many others consulted, that legislation may ultimately be enacted which will make it essential for all who nurse for hire to make such preparation as will enable them to comply with a minimum requirement before beginning to nurse, or during a specified time while continuing to nurse; and while it is believed that an enlightened public opinion will in course of time demand that such preparation be made, and that such legislation, when backed by an intelligent public opinion, will greatly assist in solving the problem of the grading of nurses, and of nursing in homes of moderate means, *the committee wishes to emphasize as of greater present importance, the securing of the active co-operation of the medical profession in any constructive effort undertaken to meet needs which so closely concern physicians.* It cannot be too strongly emphasized that if a practical working solution of the grading of nurses, and of how best to promote economy and efficiency in household nursing, is to be reached, it must be done with the sanction and co-operation of the medical profession as represented in local communities, and that local medical health officers and boards can render official service to the cause, which is of great value.

There is great reason to believe that with the co-operation of the medical profession and public health officers in a given community, and the adoption of the plans and standards herein outlined, many of the abuses which have flourished in the American nursing field may be gradually abolished. Many of these abuses, notably the custom which has grown up in many places of making exorbitant charges for totally untrained and unskilled nursing, exist because of the lack of any responsible local organization, which, acting on the principle of "this one thing I do," will devote itself to meeting such needs economically and efficiently.

### *Section 8. SPECIAL RECOMMENDATIONS.*

(1) The enormous development of tuberculosis hospitals and sanatoria, in recent years, the difficulty of securing hospital graduates in sufficient numbers for routine work in such institutions, and the fact comparatively few general hospitals provide for adequate instruction and experience in this branch of nursing, have led to the introduction of the branch of nursing, have led to the introduction of the training of nurses in many such institutions, in order to provide intelligent care for those sick with tuberculosis. In view of this fact, the committee suggests that effort be made to bring to the attention of the authorities of such institutions, the recommendations contained in this report regarding the one year course for certified nurses. It is expected that a fully trained graduate nurse will always be employed to supervise the nursing in such institutions, and assist in the training of those who enter for the course.

(2) Whereas maternity nursing furnishes, and will continue to furnish, a large part of the demand for certified and household nurses, the committee desires to call special attention to this need, and to urge that in all hospitals or schools giving the one year course, special emphasis be placed on instruction in maternity nursing, with special reference to average home conditions, and that as far as possible community facilities for gaining experience with this class of patients be utilized, under proper supervision, as is now done in connection with medical students.

(3) In view of the importance of the work, and of the diverse factors to be considered, the committee suggests that another year, at least, should be given to the study of the details regarding supervision, organization, and extension of facilities for providing efficient and economical service to the sick in homes of moderate means, before submitting fuller recommendations, believing that in the constructive work which is needed, the additional time and experience will undoubtedly result in a broader outlook, clearer vision, and wiser planning.

## IN CONCLUSION.

In the first decade of the twentieth century there was witnessed in the United States and Canada, a degree of activity in hospital building, and general expansion of institutions for the care of the sick, that has been unprecedented in the history of the world. The committee expresses the hope that in the second decade of the century there may be seen a corresponding activity in the study of community needs, and constructive effort to establish an efficient system of nursing service in homes of families of moderate means; that the members of the American Hospital Association to whom great responsibilities have been entrusted, may have a large part in determining the character and quality of such nursing, and in the general development along sane, practical, helpful lines of this form of social service so closely related to hospital work.

The committee on grading of nurses has endeavored to take a broad view of the field, and to square its recommendations with conditions and needs as they are, with the highest good of all the institutions and individuals, and different classes of people concerned, as its chief objective point. It submits this report, asking that it be not considered as a finished plan, but rather as a beginning, a contribution toward the effective working out of a complex sociological problem, which concerns a large part of the population in every city, state, and province, a problem which cannot properly be divorced from the question of how best to promote economy and efficiency in hospital management, nor from hospital development in America.

CHARLOTTE A. AIKENS,

EMMA A. ANDERSON,

IDA M. BARRETT,

R. BRUCE SMITH, M.D.

P. E. TRUESDALE, M.D.



## THE GIST OF THE RECOMMENDATIONS.

A system of grading similar to that which exists in the teaching profession.

The various classes or groups of nurses to be reduced as rapidly as possible to three—registered or graduate nurses; certified nurses and household nurses—grades A, B, and C, with a recognized standard of instruction for each class, as is the case with teachers.

The foundation studies in bedside nursing and allied subjects, usually covered in the first year, to be the same in all hospitals, irrespective of size, or of class of patients.

Grade B or certified nurses to be trained in small hospitals of under 25 beds, and in special hospitals, sanatoria, convalescent homes, etc.

That, as rapidly as possible, city or county organizations and centres be brought into existence to be devoted to the specific purpose of supplying efficient nursing to middle-class families and to standardizing household nursing.

That a fully trained hospital graduate nurse be in charge of the details of such nursing in each centre under the supervision and direction of a representative board, as is the case in a small hospital serving a community, or a visiting nurse centre.

That a serious effort be made through organization to effect a better distribution of hospital graduate nurses and to secure the more general use of such nurses in acute cases, the ultimate aim to be to fit the nurse to the needs of the case, providing a graduate nurse where a high degree of skill is needed, and a less skilled and less expensive worker where such will fully meet the need.

A recognized minimum standard of instruction in practical nursing to be required of all who nurse for hire, so soon as local facilities for household nurses to acquire such instruction be provided.

That active effort be made to secure the co-operation of the members of the medical profession and of public health officers, in establishing an efficient system of household nursing for families of moderate means in each community.

That in each institution and training centre a course of instruction in maternity nursing be provided for.

That because of the importance and complexity of the problems involved in getting a business-like system of household nursing established, the association should continue the study, for another year at least, by the continuation of the committee or the appointment of a special committee on household nursing.

That the special committee on household nursing be authorized to promote the adoption of the recommendations of this association, and to co-operate, as may be desirable and necessary, with other organizations in developing household nursing centres, which will serve as demonstration stations in which medical, economic, nursing and sociological aspects may be carefully studied, to the end that the most efficient system possible may be established.

#### DISCUSSION.

DR. KAVANAGH: I move, sir, that the request of the committee be granted and that they be continued for another year in the study of this report, and I would also move that the paper just read by Miss Riddle be formally, by vote, submitted to this committee for consideration. Nobody could hear this report without being deeply impressed with the scope of the subject. There are many strong things in the report, and I move that the whole matter go back to the committee, according to request, for consideration during the coming year, and if that is passed, it would be proper for somebody, and I might as well do it myself, move that an allowance of at least \$500 be granted to this committee in connection with its work during the next year. As I understand, they had \$300 last year, and \$300 was not enough; \$300 compelled them to come here with a report that was not completed, probably if they had had more money they would have had one or two more meetings to more fully digest some matters, and if that is the case, I would suggest \$500 as the minimum amount to be assigned to them for that purpose. Therefore I move that the committee be continued to work on this report next year, that Miss Riddle's paper be especially brought to their attention, and that \$500 be appropriated to carry on their work.

PRESIDENT: You have heard the motion.

DR. MANN: Is that motion open for discussion?

PRESIDENT: The motion has not been seconded. The motion is seconded. It is now open for discussion.

PRESIDENT: You have heard the amendment. Do you accept the amendment, Dr. Kavanagh?

DR. KAVANAGH: I would suggest, if Dr. Mann would accept it, that the President, two Vice-Presidents, whoever they may be, I don't know, but they ought to be good men or women and I am willing to take a chance on them, that those three be added to the committee.

DR. MANN: I believe that that is not a representative committee, and I should like to offer an amendment to add three other names to that committee, men who are more representative of the larger hospitals.

PRESIDENT: You incorporate that in your original motion?

DR. KAVANAGH: Yes, in my original motion.

DR. MANN: I do not accept that. I accept the President, but I do not accept the two Vice-Presidents. My amendment would read: That the President appoint three additional members to that committee from superintendents of the larger hospitals.

DR. BABCOCK: I second that amendment.

DR. KAVANAGH: I think my motion is a good motion.

PRESIDENT: The amendment is before you for a vote.

SECRETARY BROWN: I should like to move an amendment. I have in mind an amendment to the amendment, and that is: That the additional members to the committee chosen shall be superintendents of hospitals who have graduated from training schools. I think this is a question that should be viewed from several standpoints, and that, as it has to do with the nursing profession, I should like to see on that committee, instead of male superintendents of hospitals, female superintendents who have gone through the mill and know something about it,—and three superintendents of hospitals who are graduate nurses added to that committee.

PRESIDENT: Is this amendment seconded?

MISS AIKEN: This question is quite vital to the small hospitals, and it does seem as though they should be represented.

PRESIDENT: Is Dr. Brown's amendment to the amendment seconded? If not, the discussion is on Dr. Mann's amendment to the motion.

DR. HOWARD: I should like to ask if Dr. Mann is willing to leave out one word in that amendment, that is the word "larger"? Not limit it to the larger hospitals. I will ask if he is willing to trust it to the superintendents of hospitals and leave out the word "larger"?

DR. MANN: No, I will not do that. You can have a committee appointed here, ladies and gentlemen, that has no repre-



sentative man or woman, that has a training school of probably not more than fifteen or twenty nurses. I believe we can have representatives on that committee, man or woman, who have training schools or hospitals that have at least 100 nurses, and I think in regard to the amendment of Dr. Brown, that they have now three women who are nurses on that committee at the present time. That is my answer to Dr. Brown.

A LADY: If the selection of the additional members of the committee is left in the hands of the President, I wish to second Dr. Brown's amendment to the amendment to the motion.

DR. TRUESDALE: I think that a very large committee is going to be much more expensive and very unwieldy. Just why I was placed on that committee I do not know. If it was a matter of courtesy I am very grateful to the Association for that courtesy, but I feel that the smaller hospital is sufficiently well represented without me on that committee. Miss Anderson has made a report for the committee. She has made a report for the majority of the members of the committee, and I may say that I am not in the majority. While there is much that is excellent in the pamphlet which has been presented, at the same time there are parts of the pamphlet which I do not endorse, and I feel that it is only in justice to myself that I make that statement now, and before asking to be relieved of any service or any further responsibility in connection with the work of this committee.

PRESIDENT: You have heard what Dr. Truesdale says. It is perhaps only fair to say in this connection that I am in receipt of a communication from Dr. Bruce Smith, the other man on the committee, who says he does not wish to endorse the report. Is there any further discussion?

DR. DREW: The situation seems to be this: The Association is not willing to accept the report, and it does not seem to me to help matters to have this committee enlarged. The matter might as well be fought out in open meeting, if it has got to be decided, , or else discharge this committee and appoint a new one, if you want to try that, but to enlarge the committee and enlarge the expense and go again and try to thrash this out is simply postponing a very difficult and delicate matter, and I think the question ought to be discussed openly and discharge the committee if you do not accept this report.

PRESIDENT: Is there any further discussion?

DR. HAWORTH: I wanted to ask just what Dr. Kavanagh's motion was. I do not understand it at all.

PRESIDENT: Dr. Kavanagh's motion was to the effect that this committee be continued for another year, that \$500 be appropriated for their use, that Miss Riddle's paper be referred to them and commended to their attention. To that motion Dr. Mann made the amendment that three members be added to this committee, who would be male superintendents of larger hos-

pitals, to which Dr. Brown made the amendment, substituting for these three men, three women who would be graduates of training schools and are superintendents of hospitals. That is the way the matter stands now, Dr. Haworth.

DR. HAWORTH: We do not understand by that that Dr. Kavanagh approves of the report of the committee?

DR. KAVANAGH: No, sending it back to the committee for further work. We did not have any report read, this is simply stating the work that they have done. This motion is to carry it back to the committee to work over and bring in next year. It does not commit us to the report in any way whatever, but the thing is too good, too valuable, too much time spent upon it, it seems to me, to simply throw it out, simply because they are not ready to make a final report. We should work on this line even if we adopted Miss Riddle's paper. We have begun a good thing and we ought to see it through.

DR. HAWORTH: I want to say, I am very much in favor of the report as given by the committee. It seems that it is time that something should be done to standardize the work of the nurses. There is no question but that the nursing field as it now is, is rather disorganized, to say the least. Most of the states have registration of nurses; as I understand, this report has nothing to do with that.

MR. BORDEN: I rise to a point of order, because I think the situation is getting very complicated; the gentleman is speaking of something not pertaining to the subject matter.

PRESIDENT: The point of order is sustained, the gentleman is not talking to the issue before the house. Is there any further discussion?

MR. BORDEN: I wish to continue by saying that I think we are pretty well mixed up. In the original motion there are three distinct propositions, and then there are two amendments concerning the makeup of this committee. It seems to me it would get straightened out if we voted down the situation as it is, and then started over again, so that we would know the point we were talking to, and I have in that connection to suggest that if we add three to the committee, you will have a committee of eight, out of which you will get no majority. If we add two, you will get a committee of seven, out of which you can get a majority, and if there be resignations, then there will be opportunity to add to that committee persons who can properly consider the questions to be considered, and it does seem to me, if you choose a proper president, with the opinions that have been expressed here today, that you ought to be able to leave it to the president to appoint members of the committee that will consider the situation from all points of view.

PRESIDENT: We will come to a vote on Dr. Brown's amendment, so that it would read as follows: That the committee is continued for another year, \$500 be appropriated and Miss Riddle's

report sent to the committee and that three women superintendents of hospitals and graduates of training schools be added to the committee.

DR. KAVANAGH: Would you allow a substitute? I have conferred with Dr. Mann, and I think we can, if you allow a substitute, the substitute would be this: My motion as it first stood, but in addition to that, the incoming president and the superintendent of a large hospital be added to the committee. Dr. Mann will second that.

THE PRESIDENT: If you add another amendment this will be so complicated that we will not get through with it, unless Dr. Brown withdraws his amendment.

DR. KAVANAGH: Well, I think Dr. Brown will.

SECRETARY BROWN: I merely made the amendment arising from a remark of Dr. Mann, in which I thought he emphasized the men superintendents of hospitals, and it occurred to me if we had on this committee some superintendents of hospitals that were graduates of training schools we might get additional light on the subject and be able to get a more valuable report as the result, and if Dr. Mann would drop the word "man" and leave it "superintendents," if that would meet the situation, I would be glad to modify my motion, with the permission of the seconder. I have the permission of my seconder in that regard.

PRESIDENT: Dr. Mann, do you drop the "man"?

DR. MANN: No, sir.

PRESIDENT: That being the case, Dr. Brown's amendment is before the house. Remembering that only active members have the right to vote, those in favor will please so designate themselves by raising their right hand. Vote on Dr. Brown's amendment. Please rise, those in favor. The amendment is lost.

The question is now on Dr. Mann's amendment to Dr. Kavanagh's motion, which reads as follows: To continue the present committee for another year, to appropriate \$500, to refer to this committee Miss Riddle's paper, and to add to the committee to be appointed by the President three men superintendents.

DR. KAVANAGH: Dr. Mann accepted two, we agreed on two, the President and one other. That is the motion.

PRESIDENT: Is that accepted by Dr. Mann's seconder?

DR. MANN: I will accept that.

PRESIDENT: It reads: To add to the committee the President and two men, superintendents of large hospitals.

DR. KAVANAGH: One the President and one a superintendent.



PRESIDENT: The President and one man superintendent of a large hospital. Those in favor will please rise. The motion as amended is carried.

Now, as I understand it, Dr. Truesdale has withdrawn, that leaves four members on the committee, the President and one other to be appointed. The report is referred back to this committee, \$500 is appropriated and Miss Riddle's paper is called to their attention.

MR. BORDEN: Do I understand the resignation of Dr. Truesdale does not leave a vacancy, so that somebody has to appoint another member of that committee in Dr. Truesdale's place, making two additional members, seven on the committee? I do not know who has authority to fill that vacancy, but it seems to me as though there ought to be some authority.

PRESIDENT: I should like an interpretation from the members.

DR. KAVANAGH: My thought in regard to that was that Dr. Truesdale had withdrawn, the point being made that the committee was too large, therefore the suggestion of one superintendent would not enlarge the committee, but would facilitate the committee. I do not stick to that, but that was in my mind at the time.

PRESIDENT: Is that the sentiment of the Association, that it shall be a committee of six, or a committee of seven? The chair awaits a motion.

A MEMBER: Is it incumbent on the President to fill vacancies on a committee?

PRESIDENT: It is a question whether there is a vacancy. The question is, whether it was the intention of the Association to make a committee of six or a committee of seven.

MR. BORDEN: If I may be excused for speaking again, I do not think there is any question but what it was the vote of this Association to add two to that committee. It was a committee of five, and after that was done Dr. Truesdale's resignation was apparently accepted by the chair, and therefore it seems to me that according to the vote, it must have been, as adopted by the Association, a committee of seven.

PRESIDENT: The chair will so interpret it, unless there is objection, and the vacant position will be filled by the incoming president. Is there any further business?

DR. KAVANAGH: There is a small matter of business that a number of us have been talking about, that there is a growing desire, and it has been suggested in some of our hospital papers, that the delegates of this body shall be taken into the inner circle, so to speak, when we come to the election of officers, more than we have been accustomed to do in the past. In the early days of the Hospital Association the rule under which we operated was most excellent, and we have had excellent officers up to the present moment, but we are a full grown society now

and I would offer this as an amendment, that is, I would give notice of an amendment of the By-law: That Section 3 of Article 4 of the By-laws be struck out. Perhaps you will read the section if you have it there.

PRESIDENT: Article IV., Section 3: The Committee on Nomination shall nominate to the Convention the names of candidates for President, three Vice-Presidents, Secretary and Treasurer. The action of this committee is at all times subject to the approval of the Convention.

DR. KAVANAGH: Mr. President, I simply give notice as to that, doing it at this time because it was the intention of the chairman of the committee to ask the Conference to elect officers on Thursday morning, instead of on Friday, if it can be done, there are certain reasons that are personal to him and to others, I believe he has to leave, and therefore I will move at this moment having given this notice, that the election of officers for the ensuing year take place on Thursday morning, immediately following the minute business, no matter what the item is, the ordinary business of the convention.

PRESIDENT: Dr. Kavanagh moves that the election of officers take place on Thursday morning. Do you also wish to give notice of the substitution of something for this?

DR. KAVANAGH: That this amendment be considered at that time.

PRESIDENT: Will you repeat the amendment?

DR. KAVANAGH: The amendment is: That Section 3 Article 4, of the By-laws be struck out, because in other places it is provided that we elect by ballot.

PRESIDENT: Dr. Kavanagh gives notice that he will move on Thursday morning: That Section 3, Article 4, be struck out of the by-laws. I should like to call Dr. Kavanagh's attention that that would involve also a change in Section 1, which says the President shall appoint a Nominating Committee.

DR. KAVANAGH: I would move that that also be struck out.

PRESIDENT: Dr. Kavanagh will move on Thursday morning that we strike out of Section 1 the words: "Committee on Nomination of Officers, three members," and strike out Section 3, which reads: (Reads). Then Dr. Kavanagh makes the motion that we proceed to the election of officers as the first business Thursday morning. It has always been the custom, according to the Constitution and By-laws that nominations shall be considered by a Nominating Committee and the names presented to the Hospital Association. As I understand it, if I am wrong, Dr. Kavanagh will correct me, he intends to substitute the method of nominating from the floor.

DR. KAVANAGH: Some method that might be determined by the By-laws, a very simple method might be devised; there could be nomination by informal ballot, and then a formal nomination and the matter attended to very quickly.

PRESIDENT: You do not intend to substitute another method, you intend simply to withdraw this method?

DR. KAVANAGH: That is the idea exactly.

DR. HURD: I merely wanted to ask a question, just what the Constitution and By-laws require for a change in the Constitution? This Constitution has been changed several times, but I am pretty sure in most Constitutions it is necessary to give notice at one meeting, or one annual meeting, and to make the change at the other.

PRESIDENT: This is a By-law, but under amendment to the Constitution it says: "Amendments to the Constitution shall be submitted in writing. Amendments cannot be acted upon at the session at which they are proposed, but may at any subsequent session. They shall be passed by not less than two-thirds vote of the members present and voting." After that come these By-laws. At the end of the By-laws, Dr. Hurd, it says: "No part of these By-laws shall be suspended, altered or changed except as provided for by Article 7 of the Constitution." So this can be voted upon at the Thursday morning session. The motion before the house is that we proceed to the election of officers on Thursday morning.

The motion was seconded by Dr. Babcock and was carried by a rising vote.

Adjourned to meet at 10 a.m.

## WEDNESDAY, AUGUST 27—MORNING SESSION.

### Section of Large Hospitals.

DR. F. A. WASHBURN: The first paper on the program this morning will be on the subject of "Inspection and Standardization of Hospitals," by Dr. John Allan Hornsby.



## Section of Large Hospitals.

### STANDARDIZATION OF HOSPITALS.

BY JOHN ALLAN HORNSBY, M.D.,

Chicago, Ill.

The growth of the hospital has always gone parallel with the development of medical science. In the day when the doctor's diagnosis was made at the bedside without the aid of any other person and without the aid of outside forces of which he was not the master, and when his treatment of the patient was corked up in a bottle of medicine, the only persons sent to the hospital were those who had no homes in which to be cared for, nursed and fed—that is, the very poorest of the poor.

With the development of clinical pathology under Virchow, Billroth and their contemporaries, there came new aids to diagnosis, aids which demanded the co-operation of a new class of medical scientists whose work was of necessity done at some central point and not at the home of the patient.

Then came the age of Lister and a tremendous broadening of the field of surgery. Men were cured of diseases that had been hopeless before; but the facilities of the hospital and the assistance of trained people were necessary for the employment of antiseptics on the operating table; a new class of patients was in this wise introduced to the hospital wards.

And came bacteriology and on its heels asepsis. If there was an impetus to operative medicine under the Listerian impulse, revolution followed asepsis, because abdominal surgery was born. Other classes had need of the hospital; and this was only the beginning.

The pathologist began to make pictures of the blood and to identify certain of these pictures as belonging to certain symptoms and certain diseases; and so his services were needed as an aid to diagnosis; and the secretions came in for like discoveries, the urine, sputum, stomach and bowel contents, and the pathologist was the daily, hourly co-worker with the clinician, and his workshop was the hospital. The X-Ray had

already come with its costly, cumbersome machinery, and that, too, was in the hospital. And so it came to pass eventually that all mankind needed the hospital.

These few high lights of hospital development are cited merely in proof that the hospital has not grown to its present high estate as an independent factor in step with an inevitable social progress, but rather was swept along by the imperious demands of scientific medicine.

But the progress of medicine has been that of a magnificently organized force. The completed task of each worker has been added to the common store. But as a recent writer has aptly said, "Until now, whatever of system has developed in hospital growth, has been due to individual hospital pre-eminence," and not as a part of a uniform, homogeneous plan.

The time would seem to be at hand therefore, when the hospital as a factor in society should think about organization, standardization, classification—system.

The first law of high achievement is comparison, and we must have the comparative factor if we are to attain the superlative. All nature is based on comparisons; the green fields would pall but for the blue hills far away, the silver waters of the brook, threading their way through, and the lights and shadows everywhere. The Great Painter has coated the birds and the beasts in those colors best adapted to secure their hiding places. Nations recognize the contrasts of color and add protection to their armies by clothing them in the olive greens, the khakis and the grays, so that the enemy will not have the shining mark that so delights the Destroyer. Navies are sent to battle in protective gray, so the enemy may not mark so well. The racer has his running mate to standardize the pace; schools adopt percentages so there will be the stimulus of the high marks. The soldier is brave when compared with his fellows; the giraffe is a dwarf among the trees and the elephant a pigmy in the hills.

So all things are measured by comparisons and if the hospital is to progress, it too must have high marks of achievement in the things that make for perfection in architecture, in equipment in administration.

But the standard that would help a weak hospital to a higher place is one thing; and the standard that

would destroy one that had not already achieved that higher level is quite another, and it goes without saying that any standardization proposed must be constructive and not destructive.

But if there are to be standards set, there comes up some new questions:

Who is to set the standards?

How shall standards be arrived at?

What shall be their scope?

Let us debate very briefly the first of these problems; all laws are made on the assumption that men cannot judge best for themselves as to their duty to society; and so a tribunal is selected to standardize the conduct of the individual, and usually the standard set is not the highest possible of attainment, but such as can be met by the average person. Laws are made not so that the few can obey them, but for the many, and those laws are standards of social conduct. Those who can do better than the laws provide, are the leaders, and set the high marks for the emulation of their fellows, and so it must be if hospital standards are to be worth while.

The hospital administrator, that is the hospital personified, is too close to the problem, too much of an interested party, to see clearly the direction progress must take. We are dreamers all, and in the final analysis, each of us has his fad and his hobby born of enthusiasm and properly so born, but that very enthusiasm makes us poor judges of the conduct of others in like occupation.

The physician is incapable of judging of hospital standards and hospital efficiency for the same reason. He has his specialty and that specialty needs certain facilities in a hospital and he is likely to be blinded to the needs of others; moreover, many physicians own their own hospitals and so it would come about that if the medical profession were asked to standardize hospital efficiency they would be in effect standardizing themselves.

Then who shall do the work? Some years ago this same problem came up in regard to the standardization of medical schools and for a long time the medical profession tried to standardize its own schools, and



made a lamentable failure of it—nothing was done, no standards were set that could be approved by enough of the profession to have any influence on the schools of the land. But eventually one of the great foundations was persuaded to undertake this work for the reasons given. It was not an interested party, but was concerned only in the good of the whole people. It had money available to make the necessary investigations to arrive at standards, and the result was that four or five years ago the Carnegie Foundation published a report standardizing the medical schools of this country which, while creating a vast furore and disapproved in many places because it had found fault with prevailing custom, stands today as the law of the medical schools, and already there has been an improvement of more than 100%, partly from the elimination of schools that could not be standardized and partly by improvement in the schools that had a right to live.

Then it may be frankly asked: Is a standardization of the hospitals intended to eliminate certain hospitals? Perhaps so, but only those that ought to be eliminated, those that are created and conducted for private gain—many of them quasi-criminal in character, maintained to exploit people and especially to exploit that class of people least able to protect themselves, the sick, the poor and the unfortunate. A standardization that has any other purpose in view would not be approved and will not be carried out; but not a single hospital created and maintained for the sick and intended to be supported by the public, either as a private institution organized under the no-profit laws, or a public hospital, can possibly be embarrassed or hurt by such standardization and, on the other hand, will be greatly aided.

How shall standards be arrived at? Hospital efficiency is a personal service and contemplates the carrying out of the doctor's orders for the benefit of his patient. This is not theory; this is practical hospital administration in its analysis. One cannot sit in an office and make standards for hospitals. One must go out and see what the hospitals are doing and how their service is meeting the demands of the physician for the benefit of his patient under the laws of modern medicine.

The doctor today requires help to make his diagnosis and for this purpose there must be a laboratory of pathology. It need not be elaborate or expensive, but it must be scientifically correct and its reports must be reliable, and to perform this work there must be trained people; for the small hospital not many, but at least one, and not all his time perhaps may be required and he may serve one or several hospitals, but his service must be exact and scientific. In this day, when even pathology is specialized and where the pathologist may not be especially trained in all the branches, there must be facilities in the hospital to perform every variety of what is known as hospital pathology. There must be someone who can give to the doctor his diagnosis of tissue taken in the operating room; there must be someone who can distinguish the various micro-organisms, make cultures of them and vaccines; there must be someone versed in the laws of serum therapy and who will be able to direct the administration of the serum in proper cases. There must be someone capable of making secretion analyses or there must be some place nearby where each hospital can have available these various aids to the physician.

The X-Ray is no longer in an experimental stage and it is needed not only for diagnosis of long bone injuries; but by its aid the doctor can now make diagnosis of bone lesions in diseases of the joints, and—we are now invading the cavities of the body and are determining diseased soft parts—calculi of the various organs can be located. Not only in diagnosis is the X-Ray valuable but recent discoveries have shown its value in the treatment of many diseases and it is necessary that the modern hospital shall be able to do this work or shall have facilities nearby for having it done.

The scientific feeding of the sick has in a very large measure taken the place of drugs in the treatment of disease, and it is necessary that the hospital shall be able to carry out the doctor's prescription in the matter of diet. Someone in the institution who has charge of the special diet department should know the chemistry of foods, the physiology of the digestion and should know how to apply these sciences to aid the doctor in his work on metabolism.

The success of surgery today depends less on the

skill and experience of the surgeon than upon the asepsis of the operating theatre, and this asepsis must be guaranteed in even the smallest hospital.

The nursing of the sick is a scientific part of hospital administration and there are certain demands of the medical profession today in the practice of nursing that must be met, cleanliness, accuracy, kindness, sympathy, all these go to make scientific nursing.

These are a few of the directions that standardization must take and there seems to be only one way to determine these standards and that is by personal investigation of each institution; and at the end of such an investigation summaries can be arrived at, determinations made, marks set.

It has been suggested in some quarters that hospital standards need only contemplate the value of the hospital as an adjunct to the medical school. This, of course, is preposterous. The time has gone by when the hospital is an adjunct to the medical school, and the reverse is true. The hospital is the only school of medicine. But the hospital is reared, supported and administered for the care of the sick and the care of the sick is the hospital's first law, and the second law is the education of those who must come after to cure disease; and therein lies the helpfulness of the hospital to the school, but first and foremost if the hospital is to be standardized it must be standardized as a place in which to take competent care of sick people, and it must not be standardized on a basis of what it can do for the medical school.

#### DISCUSSION.

DR. F. A. WASHBURN: Before Dr. Hornsby's interesting and valuable paper is open to general discussion it will be discussed by Dr. Ernest A. Codman, of Boston, who is Chairman of the Committee on Standardization of Hospitals, Clinical Congress of Surgeons.

DR. E. A. CODMAN: It is impossible for me to address the President at first, but I will address the Superintendents of Hospitals, because I feel it a great honor to appear before you, and I am filled with sensations which I never experienced before any other audience. I remember seeing a picture in "Life" of one of the vivisectioners after death with the ghosts of all the animals about him, and I feel that having criticised the superintendents of this hospital so much that I am in very dangerous society.



Dr. Washburn is President, and as a rule it seems best to pitch into the highest person or the highest hospital or the highest authority of any union if you want to raise a standard, and as Dr. Washburn is the head of this Association it is my idea to pitch into Dr. Washburn.

This spring I had the pleasure of reading a paper in Philadelphia on the subject of "Standardization" and in order to make the observations clear I constructed this diagram. I am sorry it is so small that those at a distance can not read the sections, but it represents the idea of the way I would go at it, if it was up to me to standardize hospitals. It is a central idea. I did the best I could with that paper and then I returned to the Massachusetts General Hospital and I thought this diagram was pretty good and so I put it in the library where people could see it.

Dr. Washburn, however, thought he could improve on it, and the first thing I knew I found this diagram substituted for mine, and this diagram represents the subject as considered from Dr. Washburn's point of view.

But you will see that the central ideas are entirely different. The central idea of this sheet I consider as affecting definitely on the results to the patients. Each one of these spokes, these radii, have to do with the results between it and the next. And my theme was that each one of those depended on the central idea.

Now, Dr. Washburn's sheet is entirely different. You see, the central idea is the hospital income, and the way he distributes it, and the hospital income comes from the invested funds, the fees that the patients pay, and various other little subscriptions, and then expended with what Dr. Washburn considers the result.

The income equals \$500,000, that was approximately what was spent in 1912 by the Board. I would put that \$500,000, multiplied by 100 and divided by the percentage of patients that are benefited.

I prepared some little remarks so that I could make this subject a little clearer.

DR. CODMAN: The central idea is that every product of a hospital is to a greater or less extent dependent on the result of the treatment of the individual patient.

1. In your annual reports to your trustees you state with pride the number of patients you have treated. What you should take pride in is the high percentage of patients benefited. If your staff by their efficient treatment of their cases benefit only 80%, when they should have benefited 90% the loss in efficiency is worse than if you had wasted 10% of the hospital income by neglecting to purchase potatoes at a reasonable figure. And yet, most hospitals make no effort to find out whether success has attended their treatment or not.

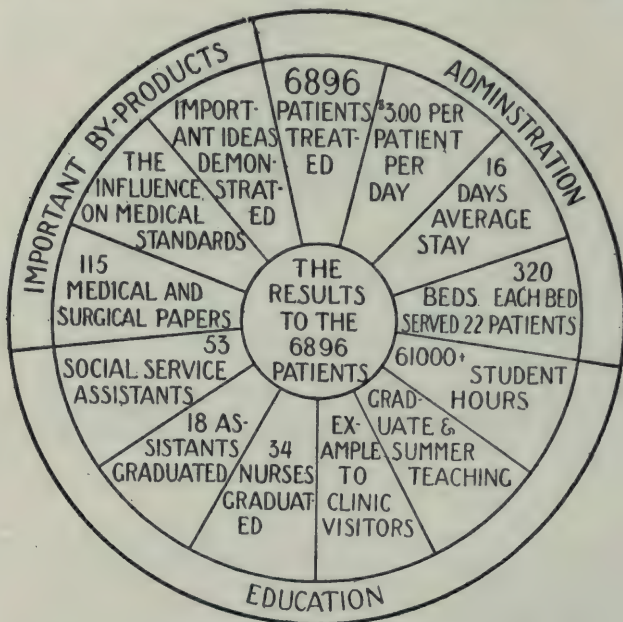
Another thing that you state in your annual reports is the cost per patient per day. Please realize, after you have carefully figured it out, that in order to obtain its real value it must

be multiplied by 100 and then divided by the percentage of patients benefited.

That is, if out of every three patients one was not benefited, your cost per patient would be \$4.50 per day instead of \$3.00.

Did you ever add up the number of days that your staff wasted by being too busy to examine the cases on the first day of admission? Did it ever occur to you Superintendents of this hospital that you could afford to pay a good surgeon a good salary from the correction of this one extravagance alone?

Again you speak of the average stay as 16 days in the hospital. Take a hernia for example. Is it economy to keep him one week or three? If your surgeons' aseptic technique is perfect, you can save thousands of dollars by discharging your clean cases in one week instead of three, but if your technique



Products of the Massachusetts General Hospital, 1912.

is imperfect and you are getting septic wounds in 10% of your hernia cases you lose money not only in proportion to your failure to obtain ultimate cure, but you are docked \$3.00 a day in all the clean cases you keep unnecessarily long, and also \$3.00 a day for all cases prolonged by sepsis!

Thus the aseptic technique of a large hospital is important enough for you to employ an expert bacteriologist to constantly follow it.

How many patients per bed do you annually treat? If your hospital is for chronic cases, the number is small; if it is for acute cases it is large. What is the cost of a thigh fracture? In this hospital I suppose thigh fractures are usually kept in bed about six weeks. At \$3.00 per day that would be \$126.00. Would it not pay us to encourage some ingenious young man to invent an ambulatory apparatus for these cases and attend them at their homes? The hospital could probably afford to pay him \$1,200 a year to do this. As a matter of fact, such is the enthusiasm of youth you could probably find someone to do it for nothing!

Did you ever calculate what a case of chronic osteomyelitis costs you? I can show you records of cases here which cost hundreds and hundreds of dollars because they were inefficiently treated in the first place!

These instances may be multiplied by the dozen. Each disease has its negative value; it costs more to cure some than it does others. In our modern hospitals you will find the senior surgeons treating the easy ones, and the difficult ones handed lower and lower down.

The truth is that the system of asking the services of busy practitioners for nothing has almost outlived its usefulness. It is time that hospitals drove harder bargains with their staffs. The hospital position is necessary to the surgeon of today and the hospital can demand of him more and more. Either he must be *made* to painstakingly treat the "lemons" or someone must be hired to treat them. They cost us too much under the present system!

You hospital superintendents are too easy. You work hard and faithfully reducing your expenses here and there—a half cent per pound on potatoes or floor polish! And you let the members of the staff throw away money by producing waste products in the forms of unnecessary deaths, ill-judged operations, and careless diagnoses—not to mention pseudo-scientific professional advertisements.

I hope that this Association you have formed together will give you strength and courage to speak up to your returning trustees as they come back brown and good-natured from seashore and mountains. Tell them that they are spending the money that is entrusted to them for a product which they give to the poor, and that it is just as much their duty to see that this product is sound and good as if it were a marketable article which they sell to the rich.

Tell them that hospital trustees that do not examine into results to their patients, do not audit their accounts! They should no more be allowed to give away death and disability to their patients than to sell worthless stock certificates.

Establish a follow-up system.

Recommend efficiency committees of three—One representative from the Staff, one representative from the Administration one representative from the Trustees—to whom you can pour out your woes.



Don't be afraid—the right is on your side.

Now I feel that this is a pretty strong statement, but I think that this Association has a tremendous power, and I feel that you individually cannot do anything with your staff and trustees, but when the trustees who are busy men, when they get an expression from you all that something ought to be done they will be ready to listen.

For that reason I feel that Dr. Hornsby's paper has brought up a question for your consideration. His suggestion that the Carnegie foundation be asked to undertake such an investigation as they did for the medical schools, is one that you can all help on. I do not know whether you choose to endorse that as a whole, but if you do it will carry tremendous weight. You represent the best hospitals in the country, and the ones beneath the recognition of this Association had better be cut out. And it will drive the members into your Association and you will wield a power that will be felt in your hospitals. Your trustees, as a rule, are kind, willing, obliging men who want to do their duty, and if you can pick out the way, they will do it, and it is the same way with the staff.

Now, the practical suggestions for each hospital that I would give are these. Establish a follow-up system, some system by which you can keep track of the results so you know whether your staff are getting good results or not. Ask of your trustees the appointment of an Efficiency Committee to consist of one member representing the staff, one representing the trustees and one representing the administration or superintendent. Now, if you can get such a committee as that, you can pour out your woes to them. Do not be afraid to ask for it. It is right.

DR. F. A. WASHBURN: Dr. Codman gives us a fresh and refreshing point of view. The subject is now open for general discussion.

DR. HURD: I think that we all of us desire the same thing, that is to say, we desire that our hospitals shall do their work in a satisfactory way. I do not believe with Dr. Codman that the work of the hospital superintendents is all in potatoes and floor polish, I do not believe in that at all and he doesn't. He has simply emphasized unduly what is perfectly apparent, that we should not waste the money of the hospital in the supplies. In addition to that, I think that he has minimized also some other work in the hospital. Many a poor person is kept in the hospital from motives of humanity who might go around at home if he had a home to go to, but you would not turn him loose on the street if he had an ambulatory apparatus on him. So that is absolutely wrong, to debit the hospital with everything it does in that way to relieve the suffering of the friendless poor, and I do not believe that is the way to get at the question.

The section that at the left hand, I do not know what the central part is about, but Dr. Washburn seems to have given the proper expenditure of the money.

I will say to the doctor in all kindness, that there are hospitals that have followed up their patients for a good many years. I know of hospitals that are constantly circularizing their old patients and finding out how they are getting along, and how much good has been done. It is impossible to show that in statistics because you can not get the results of treatment in all the cases. You can't do it. You can only get a small percentage.

I do not, however, rise to criticise Dr. Codman's remarks because I am thoroughly in accord with the general idea, which is that every hospital should secure the very best possible surgeons which can be obtained. We all know as hospital superintendents, and we all try to remedy the difficulty, we all know very serious miscarriages have come because the heads are very busy men, sometimes busy about things which they should not be busy about, large practices outside, long vacations, writing papers, and going to deliver addresses at the ends of the earth, and frequently the service is not what it should be. But I do believe that the under physicians and surgeons are doing their duty just as thoroughly as they can, many of them over-worked and underpaid, but I believe the hospital service of this country will compare favorably with that of any country. I am in favor of a salaried permanent surgeon and physician who spends his whole time in the service of the hospital.

Now, as to how this matter shall be done, I do not know that it is absolutely essential that it should be done through the Carnegie Foundation. I think that is probably the best way, yet at the same time, it seems desirable that we should in some way have a consultation with this committee that will push the question of hospital standardization. The American Medical Section has a hospital section which has appointed a committee on Standardization and Inspection of Hospitals.

I understand that the American Surgical Association has something the same way.

It seems that we, as members of the American Hospital Association should endeavor to co-operate with these bodies who are trying to secure a better classification and knowledge of actual conditions.

I have in my hand some resolutions which at the proper time I will offer.

DR. F. A. WASHBURN: Dr. Hurd, this is just a section and probably the proper time will be tomorrow when we all get together.

The beds for an ambulatory thigh fracture or one of those cases which do not need the expensive beds in a hospital is a side issue, but it brings to my mind forcibly the arguments for a country branch. I do not want to introduce another subject but if each general hospital had a branch in the country we could keep the expensive beds in the city for more acute cases, and the patients could have what is difficult to get in the city, quiet, and plenty of good, fresh air. This is a very important thing.

Is there any further discussion of these two papers? It is a very interesting subject.

MR. R. P. BORDEN: I am just wondering what was going to happen with reference to the State, what the source of good would be. What is the intention? Is it the intention that the reports of the Boards are to be prepared and then that the most efficient will be considered the standard? Or just what is going to be the result?

It seems to be a very important question just at the present time because I think there is a certain amount of benefit due to some State regulations. We have started in by an inspection of Lying-in Hospitals. Hospitals cannot carry that on unless inspected by the State Board of Charities which is a considerable benefit.

Going further, there is a considerable agitation at the present concerning the licensing of tuberculosis hospitals, and several of the people here today are preparing to advocate in the Legislature the licensing of all hospitals from year to year, with a withdrawal of the license unless the hospital conforms to a certain standard.

To those who are familiar with the situation the wickedness of certain people who cover themselves under the name of hospitals, is becoming tremendous, doing it all for their own personal profit and with very dangerous results to those who entrust themselves to their care.

But a large percentage of the hospitals, including both public and private hospitals, have fallen far below the standard that is set by the Massachusetts State Board of Charities, so that this Association ought not only to advocate an inspection and report of the hospitals, but ought, if possible, to find some way of carrying into effect the results of such reports.

DR. F. A. WASHBURN: Will Dr. Hornsby and Dr. Codman take notes of the questions asked? Any further discussion?

DR. S. S. GOLDWATER: I should like to say a few words with reference particularly to the subject of efficiency in medical work. There are vital questions in regard to medical efficiency that are not ordinarily considered and which if understood might lead to better work.

What form of hospital organization makes for efficiency? I do not refer to the question whether or not salaries should be paid to the staff, I do not mean whether or not the visiting surgeon or visiting physician sees the patient promptly after his admission, for that can be covered by establishing the rule that each patient admitted shall be seen within a certain number of hours. A broader and more important question is the question how the staff should be grouped in order to guarantee from the outset, the proper and necessary care of each individual patient.

If you undertake to standardize hospitals you will have to begin with an intelligent classification of hospitals. And when you get your hospitals classified you will go a step further and ask which of the several classified types of hospital is the type which deserves to be perpetuated. We have general hospitals and we have special hospitals, and we might be disposed to assume at the outset that both kinds are justified in their existence. On endeavoring to account for the existence of special hospitals



which had been subjected to criticism, an English writer said that the reason the different special hospitals came into existence was because the special branches of medicine were not properly recognized by the general hospitals. Finding they could get no foothold in the general hospital, specialists were compelled to seek an outlet for their talents; they gathered about them sympathizers who would support them, and so special hospitals sprang up. That statement is historically correct, but while it explains the historical origin of special hospitals in Great Britain, it does not touch the main question whether the special hospital should or should not be countenanced today.

If medical efficiency is what we are after it must be an efficiency that really produces results. If we have a medical staff to look after our patients, they should be so organized, controlled and co-ordinated that no matter what happens a patient while he is in the hospital, no matter what disease complication arises, there is assurance from the outset that what is required for the patient's good will be done. Now in a special hospital devoted to otology it is fair to assume at the outset that the patient is not in safe hands if while being treated for ear trouble, he develops a complication requiring the services of a physician of a kind not included in the staff organization. Let me give an illustration. Not very long ago I was called to the telephone by the superintendent of a special hospital in New York City which limits its work to ear and throat disease. The superintendent said a patient whom they had admitted for middle-ear disease had developed pneumonia, and asked if we would take that case and treat it. I said that I was very much opposed to transferring a patient with pneumonia from one hospital to another, whereupon the superintendent said there was really nobody on his staff that had very much knowledge of pneumonia or of general medicine. Upon his assurance that he would assume all responsibility for the transfer, I reluctantly consented to take the case. When the patient came up we found he was suffering from purulent arthritis, and did not have pneumonia at all. It is safe to say that there are a great many special hospitals where the same thing occurs. The specialist has his uses, but his limitations are obvious. He rarely makes a thorough general physical examination of any patient, nor can he reasonably be expected to diagnose conditions that lie entirely outside his own sphere of work. For this reason he must be supported by Association with other practitioners. A hospital where such a co-operation cannot be made a routine practice is not a good type of hospital.

DR. HOWARD: I would like to say just a word. I have been interested for many years in the question of general hospitals having some form of inspection from the outside. I think it would do them all good, even the best of them, just to see how others view them. I advocated this inspection some three years ago. I do not know how it is best to get it, but any form of honest inspection I think would do the general hospitals good, it would gradually bring them to a better standard, every one of them. Whether they should be standardized with relation to each other I am not sure.

I think, too, that this inspection should not be started in too drastic a manner. I go back to the time when I first became a superintendent and I called into the office an officer that I thought was a very good officer, but who had some rather bad faults. I criticised this officer so severely that he said, "There isn't much use of my hanging round here as you evidently think I am not worth anything. I had better pack, hadn't I, doctor?" I had to take considerable time to convince the man that I would not have wasted all this time in criticising him if I had not thought there was the basis of a good officer in him. I told him that when I came to the conclusion that an officer was of no account I did not call him into the office and tell him all his faults, but that I got rid of him. When I called him in to go over the points wherein there were deficiencies it was my intention to improve those points. I think that was as good a lesson to me as it was to him. I have since then looked out that my criticisms of the officers that I wished to improve were not so drastic.

There are many hospitals that would do good work if they knew what there was the need of. You need inspection. You need to go about and feel your way, criticise them for their faults and praise them for their good points, to get each one to improve. Then after we have felt our way along for awhile and got them to improve, we ourselves will know better what we want, but in the meantime we would be improving all these hospitals little by little, and this would be better than running in a haphazard way.

The end results would amount to something. They have been feeling their way in some of the hospitals, some of them for the last fifteen years, but they think they have just begun to do it, but they have results, feeble to be sure, but in a way it comes from outside inspection because somebody saw that they ought to be doing something of that sort to perfect their records in the first place.

That is all I have Mr. President. I was very sorry I was unable to get here in time to hear all of Dr. Hornsby's paper.

DR. PREST: For some time our committee has been very much interested in better staffs and trustees for medical efficiency. In searching round for ideas there was called to our attention an article of the Department of Health of the City of New York.

Some of these came today, this morning, and they are with Dr. ———, the registrar at headquarters. There are fifty copies, which we would be very glad to have the Association look into. As near as we can see it forms a very convenient method of deriving standards of what other hospitals are doing.

DR. F. A. WASHBURN: Further discussion?

DR. GREEN: In taking up this subject from the standpoint of the financial side. If you wish to get people to invest in a corporation or philanthropy, they are much more likely to invest if they have a definite knowledge upon which to base their judgment. I think you will all agree that the general public is very much in the dark with regard to the real needs and

limits of various institutions. The hospitals themselves are very much in the dark. You can ask a hospital "What is your per capita?" and they will answer, "Well, we do not know." "Why don't you find out these things?" "Oh, there is too much red tape to it and then there is the expense and our contributors do not care whether we spend \$2.00, \$2.05, or \$1.75 for a thing they have got confidence in us." Then you wonder why people do not give more readily.

It seems to me it is to the interest of all charitable institutions to show that they have delivered the goods and to show how much they have delivered.

I have known of people who have a large amount of money to distribute among the hospitals and we propose to disburse the amount with respect to the number of free hospital days they have given and from the reports that we sometimes receive, we have such cases as this. The hospital claims to have given so many thousand days of free treatment. When we ascertain how many beds they have and figure it up, we find the proportion is twenty thousand times less than the number of free days they claim to have given, in addition to pay days as well. That is, of course, absolutely impossible. As to what the per capita costs are, they had too many dollars and yet you multiply that by the number of patients they had in the whole year and you find according to that they have made three thousand dollars.

Some hospitals retain their patients on an average of eleven days, twenty days, sixty-nine days. What is the reason? I think that until the hospitals are willing to spend the necessary time and expense to find out these facts, it will be difficult to get a largely increased contribution, but when you can show the actual work, then you can go to people with some confidence, and I heartily endorse anything towards standardizing the work and the records and the accounts, so that they can be compared.

DR. F. A. WASHBURN: As we have two other papers the discussion will close here and I will ask Dr. Codman to discuss this a little further.

DR. CODMAN: There is just one word I should like to say in regard to Dr Hurds' criticism. He said he did not understand what was the central point of my diagram and then made his comments. The central point of my diagram is the result to each of the 6,896 patients, that is, the actual result to the patient. Was he cured, or wasn't he? If he had a hernia and he was operated upon and it immediately reappeared, I regard that as a waste product. It has nothing whatever to do with the kindness to a patient. I think the trustees should look into the hospitals and make sure that the patients are treated kindly. Lord knows there are complaints enough from any hospital. That is what we are attending to now.

But what I should like to see is that the trustees should assure themselves that the results that are being obtained are as good as they ought to be. Let me illustrate that by conditions in Boston. In the Carney Hospital one man serves through the whole time. In the Massachusetts General Hospital the ser-



vice consists of 18 men all of whom are almost, or over forty, with a great deal of knowledge and experience. At the Peter Bent Brigham Hospital the physician has two young men under him, able young men, who are younger than any of the staff of this hospital. We all want to know which is going to have the best service. Unless the Peter Bent Brigham Hospital will publish its results, and this hospital will publish its results and the Carney Hospital will publish its results, how can we tell? Take the reports and go over the Massachusetts General Hospital report, the Boston City Hospital report, and the Carney Hospital report and you will have your eyes opened. You will find something there that you can look into. There must be a reason for it. If the Peter Bent Brigham Hospital is improving on the other hospitals we want to know it, we want to have a knowledge of their end results.

DR. HORNSBY: Just one word in answer to Mr. Borden. I never wrote so hard a paper so unsatisfactory a paper in my life. Perhaps I was too close to the problem, but the gentlemen who have discussed the paper have made out the case for me. Dr. Goldwater has shown definitely one of the directions which standardization must take. Through the kindness of Dr. Hurd, Mr. Hoffman is undertaking a serious work in regard to a standardization of statistics of hospital records of various sorts.

My thought in presenting this problem years ago, once five years ago before this Association at Toronto, and later on in the American Medical Association, with the end in view and the avowed purpose of bringing the matter by force before the people of the hospitals. They did not come to these meetings. They could come to the Hospital Association and the purpose was to compel them to discuss the problem they were finding fault with. The method of standardization given by Mr. Borden is indefinite.

Prof. Pritchard had selected a man who could investigate the problem in issue in the way no man in the medical school work could have done.

I ought to confess, I think, that already this committee has done some work and to confess that they have looked toward other methods of approach to this problem. We have felt that if we could present the problem with a fair representation of this Association that the people who did that invaluable piece of work for the medical school would do quite as able work for the hospitals.

I am quite sure that the Carnegie Foundation, more than any other body can force improvement in the hospitals, except by public opinion, just as in the case of the Medical Schools. In a few cases perhaps State legislation has helped but that was the force of public opinion. I have no doubt that the same public opinion properly brought to bear will bring about the necessary force without reference to any other force.

DR. F. A. WASHBURN: The next paper on the program is on "Record Keeping at the Massachusetts General Hospital" by Dr. Byam Hollings, Assistant Administrator, Massachusetts General Hospital.

## RECORD KEEPING AT THE MASSACHUSETTS GENERAL HOSPITAL.

BY BYAM HOLLINGS, M.D.,

Asst. Superintendent, Massachusetts General Hospital.

The records at the Massachusetts General Hospital which concern patients are separated into two main divisions — the Out-Patient records and the hospital histories. These two divisions are in charge of a record clerk and her assistants in the Out-Patient Department and the librarian and her assistants in the hospital.

In the Out-Patient Department, the 223,000 records are centralized in the record room. They are filed in drawers which contain 60 records each, and on each drawer is a card which indicates the range of numbers within. The histories themselves are of thin cardboard 6" by 9 $\frac{3}{4}$ " and are placed lengthwise in a brown paper folder, the rear sheet of which extends slightly beyond the front so that the history number which is also printed on the inner side of the projecting brown leaf is visible on opening the drawer. Beside this, to facilitate the work of locating the desired number, there are markers which separate the histories into groups of ten.

When the patient arrives for the first time, he is given a blue linen card on which is written his name, hospital number, and the department to which the admitting physician in the Out-Patient Department considers he should be treated. If the physician is unable to decide by questioning, he makes a brief examination in one of the adjacent examining rooms. The number is stamped on his history and opposite the printed words is typewritten his full name (no initials are permitted), age, address, occupation, birthplace, race, and whether married, single or widowed. This blank history card is sent by a small hand elevator and thence by messenger to the department indicated. The patient after guiding, reaches that department which he may have discovered is printed on the blue linen card in his pocket or hand, and the student or house officer proceeds to ascertain and enter on the history card the facts concerning the patient's occupation, family tend-

encies, past history and present illness. The urinalysis is also added in medical cases and the patient appears in a single room ready for the visiting physician. The results of his examination and the medication given are noted on the history and the diagnosis which must fall within the limits of the proscribed nomenclature, which is posted in each clinic, is written at the bottom of the history in a separate space opposite the word diagnosis.

If a final diagnosis is impossible, a preliminary diagnosis must be written in a space designated for that purpose. At each subsequent visit of the patient a date is stamped on a separate line and the course of the day's examination and treatment is noted. If the patient is sent to another department for consultation or is referred for an opinion, the record is stamped to that effect and sent to the other division. The report of the physician consulted is placed after the stamped inquiry. If the patient is transferred to another department, the whole history is redirected to that department so that thereafter it comes directly to that last medical division whenever the patient visits the Out-Patient Department.

At the end of each clinic day, the histories are collected, sent to the record room and filed. Each of the old histories is replaced in its folder which is removed from the drawer at the time the history is taken out. Each new history is placed in a folder which is numbered to correspond to the history. In addition two small cards are made out for each new patient. One with the name, as Woods, James Herbert, with the address, age, out-patient number and diagnosis, is placed in the *name* catalogue. The other small card headed "Pleurisy" and followed by the name, age, address and out-patient number is placed in the *diagnosis* card catalogue. When James Woods calls for treatment his number is sent to the record room and the history is located directly by that number, and sent to the department indicated. By means of the diagnosis catalogue, the investigator interested in groups of cases may find these cards assembled and be able to locate the histories, and the teacher in the same way has his material easily accessible.

The Social Service records in the out-patient department are retained in that department but there is evi-



dence on the patient's history in the record room that there is a full sociological record also on the cases when an investigation has been requested by the physician. The value of these records is considerable, as the physician is enabled to visualize the home surroundings of the patient and the treatment is modified accordingly. If the treatment seems unsuccessful on account of the patient's ignorance, carelessness, or lack of money for absolute necessities, the report of the social worker reaches the real reason and results may then be obtained. In consequence of thorough social work there is less waste effort on the part of the physicians and less waste of hospital facilities because the cases are followed until results are accomplished.

By this simple system in the Out-Patient Department, of the history card, the name and diagnosis catalogues, each distinct but filed in one central place, and the sociological record, we have a method by which the records are quickly obtained, are accessible to the authorized investigator and are safe from loss or mutilation. The patient does not at any time handle his own record and no one outside the medical staff of the hospital is allowed to see the records. If a record is temporarily loaned within the hospital, the borrower signs for it, so that it may be traced. The record room librarian reports to the Out-Patient Superintendent the histories that are unsatisfactory from lack of diagnosis or other necessary information and these omissions are corrected by the department responsible.

In the main hospital, there are collected in some 1,730 volumes all the records from the time that records were first taken at the Massachusetts General Hospital. Not a record is missing for this period of about ninety years.

When the patient applies for admission to the wards, the admitting physician in the main hospital fills out a slip on which appears the following headings: date of admission, ward, service (medical or surgical), name in full (initials are not allowed), residence (in full), age, color, married, single, or widowed, full address of a relative, name and full address of a friend; also the name and full address of the patient's own physician. This slip is copied by a carbon sheet on to a similar sheet. One of these goes with the patient by messenger

to the ward and is known as the "nurses' slip", the other remains in the office and the data thereon is transferred to a large book and extends across two pages on one continuous line. At the same time this slip and this line are stamped with the same number. This is the patient's hospital number. The information on the slips made out by the admitting physician is gathered with care, and the slip is marked "Correct." The word "Correct" permits the nurse in the ward to use that data for the head of her chart sheet. If, owing to the fact that patients may be admitted by others less careful than the admitting physician, there are slips without the word "Correct", the nurse may not use any of that data for the chart sheet until the clerk has questioned the patient or his friends carefully, remedied any errors and stamped the slip "Correct." This seems perhaps an elaborate procedure but its value has been amply justified, by the results in tracing cases after leaving the hospital and in locating the records for court use, for physicians and for teaching purposes.

Each day the custodian of the records inspects the charts of the patients discharged on the previous day and compares the data thereon with the data which has been marked correct on the "nurses' slip" which is attached. Each Monday the charts and histories of the patients discharged during the previous week are received and inspected for completeness, accuracy and neatness. The chart sheet indicates under appropriate headings whether the patient has an Out-Patient history and whether there are any other hospital records on the same case and if so the numbers are given whereby these records may be located.

Frequently it happens that a patient enters a medical service and is transferred to a surgical service after consultation. In such a case, the medical history ceases at the time the patient leaves the medical ward and a surgical history along the same lines is begun in the surgical ward. The medical history is eventually bound among the medical volumes with reference to the number of the surgical history which is also on file in the surgical records. The surgical history shows the number of the medical record so that the one record may easily be consulted in connection with the other if so desired.

At the end of a year a letter is sent to all surgical patients, except those who die in the hospital, requesting them to return to the hospital for an examination. If they are unable to return they are requested to describe their condition and certain leading questions are asked. In this way the end results may be added to the surgical histories, already filed, and the patient is also benefited by the advice given at the time of examination.

The method of cataloguing these 1,730 volumes in the main hospital is of value as it has been found that under this system, the patient's record can be presented in from one to three minutes.

The pivot of the system is a white card 5" by 8". This has the admission data and is headed by the patient's full name. The size of the card allows for the additional headings of preoperative diagnosis and post-operative diagnosis, anæsthetic, important points in the operation, and complications of the convalescence. For a medical case, there is a similar card with appropriate headings such as preliminary diagnosis, final diagnosis and complications, object of coming to the hospital, and condition at time of discharge. In other words, a miniature history is presented as soon as the patient's name is located, and the complete bound history is indicated by a number on the card.

In addition to the name catalogue, there are three card catalogues, two of which are for surgical cases and one for medical. The surgical cards are made out in duplicate. One card is filed in the catalogue of diagnosis and the other is filed in the catalogue of anatomical regions. For example, the record of a patient suffering from ankylosis of the knee would be filed under the anatomical region of "knee" and the subheading of "ankylosis." It would also be filed in the diagnosis catalogue under the main heading of "ankylosis" and the subheading of "knee." The medical cards are, in general, grouped by the diagnosis, as for example under "Diseases of the Arteries" will be found the subheadings of Aneurism, Aortitis, Arteriosclerosis, Dilatation, Embolism, Endarteritis, etc. The diseases of the main organs of the body, however, are grouped under the headings of the organs affected.

In summarizing briefly we may notice these points:

(A). In the Out-Patient Department—



1. The records are centralized and are in charge of a record clerk and four assistants.

2. The patient does not touch his history, neither does any one not intimately connected with the institution.

3. The Social Service record reenforces the medical record when investigation is requested.

4. The admitting physician in the Out-Patient Department reviews the records and requires the correction of omissions by the department responsible.

(B). In the Hospital—

1. The histories are centralized and are under the care of a librarian and her five assistants.

2. Four card catalogues.

- (a) One in which all the hospital cases are filed alphabetically, by name, on which is a miniature history.

- (b) Two surgical catalogues, one anatomical, one with diagnosis. Each surgical case is filed by the anatomical region affected and by the diagnosis made.

- (c) One medical, in which affections of the main organs of the body are grouped. Cases are filed by the diagnosis under those organs, and all others by the diagnosis alone.

3. Great care is taken to obtain absolutely correct information concerning the patient's full name, correct address, names and addresses of friends, etc.

4. The charts are inspected on the day following discharge, for accuracy, neatness, and completeness. Histories of patients discharged are inspected each Monday.

5. The catalogue cards when ready to file are inspected by the librarian.

6. No one, with the exception of the hospital staff and house officers, are permitted to see the records. An abstract or copy may be given under proper circumstances. The records when summoned to court are held in the possession of a hospital representative.

7. After one year, all surgical patients are asked to return for examination and a catalogue is kept of the results of these examinations.

This "end result" catalogue requires the entire time of one clerk.

DR. F. A. WASHBURN: There is one further point for Hospital Standardization. This is to follow up cases that have been discharged. The board has put at the disposal of the staff a clerk who will send out letters to any class of cases. Not only are all the out-patients circularized at the end of a year but nearly all of them a good many times. Sometimes fifteen or twenty years after they have left the hospital.

DR. FOWLER: The greatest compliment I can pay that paper is that I would like very much to have a copy of it. When I was leaving my home in Louisville, Ky., my secretary asked me to see if I could not obtain the method, and I would appreciate a copy of the paper very much. Any cost that would be attached I would take great pleasure in taking care of.

DR. F. A. WASHBURN: Dr. Hollings will be glad to give you what you wish.

The next paper on the program is on the "Report of Committee on Hospital Construction," by Dr. John M. Peters, Supt., Rhode Island Hospital, Providence, R.I.

## HOSPITAL CONSTRUCTION.

BY JOHN M. PETERS,

Supt. Rhode Island Hospital, Providence, Rhode Island.

A report on a subject so broad is a difficult one to make, as it can go into details so numerous as to become unwieldy or it can be limited to some specific line of work in which the writer may be especially interested.

Hospital construction in our country has been improving rapidly especially during the past twenty years. The need of special knowledge and experience in the work is being recognized more fully every year as is shown by the employment of specialists in this line of work chosen from our own members who are called in as consultants and also from architects who have been wise enough to see the great field open to them.

This association of ours has been, in my opinion, a most potent factor in getting better plans for and better construction in our buildings. Take our meeting here in Boston this year as an example. Can any one attend without going away with new ideas as to construction, arrangement of space, use of different materials, style of construction, equipment, etc?

The founders of this Association built better than they knew, and all of the institutions in the country are and will be better for the existence of this Association.

The establishment of a bureau by one of our members who has had practical experience as a hospital executive, to work from the beginning with architects, trustees, medical staff, superintendents of nurses, housekeepers, etc., so that before the work is begun, a complete list of equipment could be made, is a step in the right direction.

In this city where we meet today there seems to be an unusual amount of Hospital construction recently completed, or now in progress.

As you know, the Peter Bent Brigham Hospital, now open but not completed, is the latest hospital of large size that has recently been erected under the direction of one of our members.



Here are buildings erected on a site close to the Harvard Medical School to care for some two hundred or more patients sick with acute disease or needing surgical interference.

You will see here every possible endeavor made to get the patients out of doors into the fresh air. You will see simplicity of exterior accommodations and appliances built and ready for the patient and the physician or surgeon. As I look at it, the aim has been service rather than esthetics, architectural or otherwise.

The imposing administration building receives the ambulatory patient on the main floor which is fitted up for service, something after the manner of a modern hotel lobby, with offices for administration and admitting officers, superintendent of nurses, etc.

On the floor below are receiving and examining rooms for patients coming in ambulances or carriages. The upper floors of this building are to be used as living quarters for the medical officers.

The wards are of two stories with an isolating suite of rooms on the third story.

The main floors of several buildings are connected by corridors under cover overhead and protected on the north, but exposed on the south.

Architecturally in time these loggia ought to be very attractive with the south side open to the lawn, shrubs and flowers.

In the north wall of these corridors are shutters which can be kept in place in winter and removed in summer, giving a better chance for air circulation.

The main features about the wards are the successful accomplishment (in a simple, practical way) of the desire to get the patient (whether he be confined to his bed or not) out into the open. The doorways are unusually wide, the space out of doors unusually ample.

Many of the wards and rooms on the lower story are warmed by directly heating the cement floors with heat coming from steam pipes which lie in enclosed metal boxes directly underneath the outer edges of the floor.

So far as I know, this is the first hospital where heating by this method has been tried, although there

are mercantile houses and factories where such a system of heating is in use.

As auxiliaries in some of these larger rooms, indirect heat can also be supplied if necessary in certain weather conditions.

In the one story wards the ventilation is by suction and by the vents in the monitor roofs.

The large amount of space given to routine laboratory work in close touch with the individual patient, such as general, bacteriological, physical and chemical laboratories, are unusual and ought to mean much to the value of the work, done as it is under the trained heads of the teaching force of the Harvard Medical School, under whose jurisdiction most of the staff appointments are made.

There are many important things developed and carried out in this group of buildings built under the direction of Dr. Howard. The construction, appliances and apparatus are simple, but are built for the hard wear and tear incidental to an active hospital service.

The heating is done by direct and indirect steam, controlled by thermostats, by the heating of the floors in certain rooms of the first floor and by hot water in certain other sections, and we ought to be able to learn from their experience which is the proper one to use to meet certain conditions.

It is complex in a way in the number of systems and the great quantity of pipe needed for such service, but it ought to be flexible and the success of it will depend much on the faithfulness of him whose duty it will be to control it.

It has necessarily been an expensive plant to build, limited as it is to two stories with patients having every facility for getting out of doors, with unusually liberal laboratory and investigation facilities, and to be used as a teaching hospital, with its attendant expenses necessary for construction and maintenance.

A silent signal system by using lights by the bedside, over the door of the ward or room and at the nurses desk, ought to help.

A large amount of space is given up to Zander apparatus for mechano-therapy and a rather complete outfit for hydrotherapy is arranged for. Off of each ward is an office for the use of the doctors who may have

patients there. This room will be used as an examining room, consultation room, etc.

Here you will find a stenographer in each ward building, ready to take the dictation of the medical men for complete records; plumbing fixtures made of vitrified china, which does not craze and which costs no more than enameled iron; bath tubs raised high from the floor for the convenience of the nurses and the bath room large enough to permit a bed being wheeled into it; opaque glass tops on the dining tables of employees dispensing with table cloths; all fixtures set out from the wall; Dadoes built of Keene's cement to stand the banging of furniture against it; two gas flames and a gas toaster in each pantry; all beds on wheels, etc., etc.

An important piece of work has been begun at White Plains, N.Y., twenty miles from New York City, by the Burke Relief Foundation. Here on a plot of sixty acres is being built a hospital for adult convalescents.

The aim of the institution is to furnish a home for convalescents of both sexes, who are properly separated, with the administration building, dining hall, etc., centralized.

The several buildings are connected by underground passages for service, and covered passages open on both sides for the use of patients, physicians, nurses, etc.

In the group of cottages given up to the care of women, is a building in which the upper stories are to be used as a home for nurses, but the lower or main story is to be given up as a social center for the women patients, where they can rest, read, etc.

On the men's side, the first floor of the male employee's dormitory offers similar accommodations for the men, and in this same building a large assembly hall is to be fitted up for the use of either men or women patients, or for the employees.

The buildings are to be of fire-proof construction and most of the floors are to be of plastic linoleum, composed largely of pulverized cork.

There are to be eight two-storied cottages for patients, each accommodating twenty patients, ten on a floor. The division of space is experimental, with rooms of varying sizes accommodating one to two or



four patients. For each of these cottages a sitting-room, bath and toilet room, pantry, rooms for nurses and a small kitchen are provided.

Level with the ground floor, wide terraces run around the building, and off of the second story balconies, afford opportunity for open air treatment. Part of these terraces and balconies can be enclosed to offer protection from storm.

In addition to these eight unit cottages, there are to be two larger buildings, one for men and the other for women, each accommodating eighty patients, bringing the total capacity up to about 250 patients.

This is probably the first serious attempt made in this country for the proper care of what we are beginning to recognize more each year, the great necessity of, i.e., the placing in the proper environment, of the convalescent, who in so many cases needs what he cannot get in the city—fresh air, freedom, quiet and relaxation.

The Burke Foundation is to offer a temporary home for the deserving poor, who after leaving a hospital, are in no condition to return to work, but who can be helped more by the rest and benefits that can be derived from the simple quiet life to be found in such a place.

#### At the New York Society for the Relief of the Ruptured and Crippled.

The new building has been occupied recently and presents some very interesting features.

On the third floor a toilet and bathroom sufficiently large to allow three or four patients to be wheeled into it in their carts or wheel chairs, and containing among other fixtures, a marble bathing slab with sink attached for the use of patients unable to be bathed in a tub.

In the wards an imported buff tile is said to give a pleasing effect.

The spectators' gallery of the amphitheatre is reached by stairs from the floor above, thus obviating the necessity of having visitors on the operating floor.. The seats in the gallery are of enameled iron, supported on brackets, and modelled somewhat like bicycle

saddles. These seats are comfortable, easily cleaned, and allow a maximum amount of space for passage.

In the instrument room there is a steel and glass instrument case built into the wall.

An assembly hall used for getting together the children who are able to attend school, as a kindergarten, a playroom, a dining hall, where dinner is served, with four classrooms for the other children who are able to attend classes, is an unusual feature.

As I understand it, the Board of Education furnishes the teacher, and the youngsters do not lag behind in their studies as they must necessarily in most of our hospitals caring for crippled children.

A large part of the sixth floor or roof floor planned for outdoor treatment and for recreation is divided into two sections, one for boys and the other for girls. A large part of these sections is roofed over, providing protection in inclement weather. A low parapet offers opportunity for view in all directions and a wire mesh screen built on top of it affords protection. The pantries, dressing rooms, toilet facilities, etc., that are provided make the floor practically self-contained for caring for any case of contagious disease that might need isolation.

Most of the windows have mullions with transoms hinged at the bottom to swing in. The transom is operated by a Lord & Burnham transom adjustor.

The interior door frame and trim are made of steel in one piece, with face flushed with the plaster.

The window frames are so constructed that the lower sash may be raised three to four inches, allowing ventilating space between the lower and upper sashes, and yet not raising the lower sash above the sill of the window.

There are tile floors throughout the wards and dispensary, and in the corridors, terrazzo floors with marble borders. A brass rail is put in the corridors to act as a guard for wheel chairs, etc., and to assist the children in walking.

The toilet article fixture is also worth noting, in that in one fixture are put the comb and brush, toothbrush cup, washcloth and towel of each individual patient.

### Mt. Sinai, New York.

On the roof of two pavilions, sun-parlors originally designed for convalescents, have been converted into permanent roof wards, one for men and the other for women, each accommodating eight beds, enclosed in glass on the north, east and west, but open on the south, which end can be enclosed by counterbalanced rolling iron shutters in case of a driving rain or snow storm. There is still left an open space, uncovered, on the roof.

### Bellevue, New York.

Two large sections of the new Bellevue are nearing completion. In one section, given up to the care of over four hundred surgical patients, several changes in the interior arrangement of space have been made, saving space and adding to the convenience of the workers. In the utility room, one of the new fixtures is a white metal sink in which bed pans, utensils and soiled linen can be sterilized.

In the other pavilion, eight operating rooms with their several accessory rooms are being constructed, leaving several rooms originally planned, but not now demanded, for future development and equipment.

After a good deal of consideration and by agreement with the medical staff, it was decided to omit all surgical amphitheatres. In the future, medical students in small groups of ten to fifteen will witness operations and come in closer contact to both patient and operator.

An elaborate institute for physical therapy is also being planned and it is expected that this will surpass in extent and equipment, that of any place in this country.

### Harlem Hospital, New York

Two ward wings are being constructed, in which the reception, classification, observation and distribution of patients have had special care. In the receiving department are waiting, examining rooms for both sexes, initial bathing facilities, separation rooms for suspected contagious diseases, small wards for cases of erysipelas and delirium tremens, an admitting ward for night cases, an admitting ward divided into cubicles for children, etc.



### Seaside Hospital, Rockaway, New York.

This hospital, to be located at Rockaway Inlet, Long Island, will, it is hoped, ultimately have a capacity of 1,000 beds and is to be used for children having tuberculosis of bones and joints.

It will be used exclusively for children, most of whom are of school age and provision will be made for their schooling, as most of them will not be confined to their beds. Special attention is being made to the space and arrangement for school rooms, playing-rooms, manual training, gymnasium, assembly room, etc., most of which will be located on the ground floors.

An observation ward in which all children will be kept for two weeks after admission will have cubicles or observation rooms. This will contain four units with a total capacity of twenty-four beds. In the general wards thirty bed ward units will be used, each connected with a loggia 16 x 32 feet, facing the south. One pantry will serve two wards. Stairways with low risers and inclines will help the children in getting from one floor to another.

As the hospital will be located some distance from the city, special attention to social life of the workers will be given.

### Samaritan Hospital, Troy, New York.

This new building accommodating 150 patients of all classes is now being constructed and has many points of interest in that the administration building facing east,, is flanked on the north by the nurses' home and on the south by a private patients' pavilion. A corridor starting at the junction of the administration building and private patients' pavilion runs west and from the south of it are two ward wings and from the north connections for kitchens, dining-rooms, operating rooms, etc.

A separate three-story building cares for employees, etc

### Stamford Hospital, Stamford, Conn.

This group of buildings was especially planned for taking care of practically all of the hospital needs of a small community, and which can expand conveniently and with harmony to the present layout. In other words, foresight was used.

### Children's Hospital, St. Louis.

The problem of caring for 150 infants and children on a site 90 x 200 feet on the grounds of the Barnes Hospital, which is in close connection with the pediatric department of Washington University, and caring for children suffering from contagious diseases as well as for children who were free from these diseases, presented an unusual problem.

Here we find the stairway and the elevator serving all floors built in the open, with no interior shaft connecting one floor with another.

There are twenty-five beds on each floor, with twelve in the largest ward and the others in single rooms or small wards with a connecting corridor.

On the ground floor a receiving ward divided into single rooms has been provided.

### Montefinore Home and Hospital for Chronic Invalids, New York.

This is one of the largest and best equipped hospitals for the treatment of chronic diseases in the country.

There are eleven buildings. This is the first serious attempt in this country to lay out and carefully plan a building for the care of incurable cases. To meet this great need, to properly care for these patients, most of whom have no quarters except those provided by alms-houses, is a problem that must be met by us in all sections of the country. A special feature is the terraced construction on one side of their tuberculosis building.

The acutely sick, the injured, are getting good care and good accommodations in all sections of our country; the chronic, the incurable, have been and are mostly badly cared for by us in our lack of provision of adequate or proper quarters for treating and caring for them. Let us hope that this stimulus will have an effect in all parts of the country.

These notes relating to the last nine hospitals were taken from descriptions furnished me by Dr. Goldwater, who is connected in an advisory capacity with all of them.

At the City and County Hospital at St. Paul, they have recently erected a service building, a laundry

building, a laboratory, and a garage and are to erect a building for the care of tuberculosis patients.

At the Johns Hopkins Hospital, the Phipps Psychiatric Clinic has been opened, the cost of this, accommodating ninety patients, is upwards of \$8,000.00 per bed, and it is said to be the last word up to now in arrangement and construction for the care of this class of patients. In this building, a doctor's call system, using telegraph tickers as instruments of call, has been installed and found to be satisfactory. These tickers are placed at intervals all over the building and simply tick the doctor's number instead of striking it on a gong or buzzer. It is clear and easily heard and not annoying.

A new laundry, well worth seeing, and a remodelled kitchen are finished.

In a new building for private patients, now in the course of construction, a three-inch gray tile for all pantries, bathrooms and utility rooms are being used in place of the white tile floor. In this building they are also using new steel corners for all door openings, and these are built into the masonry so that they form part of the wall with the plaster finishing flush with it. They are firm and immovable.

In the corridor floors they are using a six-inch marble base with a marble slab border fifteen inches wide and thirty inches long; in the center, Battleship Linoleum is laid flush with the marble, making an attractive and quiet floor for a corridor.

In all their new buildings they are making use of the old-fashioned lever handle in place of the door-knobs, for convenience, looks and cleanliness.

At the Massachusetts Homeopathic Hospital, the Evans Memorial Building has been occupied during the year. This building, given up to clinical research and preventive medicine, is rather unusual in that it contains a large hall on the ground floor in which lectures to the public on medical topics are given at regular intervals by members of the staff.

At Jacksonville, Florida, a group of eight buildings practically detached, similar to the German hospitals, is being built. Among these buildings the White Isolation Pavilion is to care for all infectious diseases in one



building, depending upon the technique and careful nursing to prevent cross infection.

At Toronto a four-storey addition for isolating such sick children as contract contagious diseases in the hospital for sick children, is being built.

Here, glazed cubicles for patients, visitors' balconies, and fresh air corridors going across the building are being built something after the manner of the construction of the Pasteur Institute in Paris.

At Bridgeport, Connecticut, a new maternity and children's pavilion containing the ward unit, used successfully at the Rigs Hospital at Copenhagen, will be found.

In other words, a large ward is divided into small units of four beds each by building permanent screens, and thus getting semi-private wards, at a minimum expense, and still retaining the advantages of the light and air that are found in the large ward.

At Wilkes Barre, a private patients' building has been designed on rather unusual lines with special reception and sleeping rooms for the nurses who are on special duty there.

In the high basement of their nurses' home, especially attractive class and demonstration rooms have been made out of waste basement space, a thing well worth thinking about.

These last seven buildings are being constructed under the direction of Edward F. Stevens.

At Grand Rapids, Mich., a new hospital, the gift of John B. Blodgett, of that city, is being erected.

At New Dorp, Staten Island, new buildings are being occupied. Here unusual construction and equipment for handling a large number of sick children at the seashore have been worked out satisfactorily.

At the Ohio Valley General Hospital, in a new six-storey building, among other things is a brine refrigeration system throughout the house. All dishes from wards and private rooms are washed in a central dish washing room. There is circulating ice water served at bubbling fountains with separate faucets for filling pitchers, etc.; all food (in many parts of the building) is served from steam tables on wheels at the bedside; the food in the servants' dining-room is served

by methods similar to those used in dairy lunch restaurants.

#### At the Hartford Hospital

Additions have been made to their obstetrical and gynecological wards.

They are trying a new dish-washing machine on which the dishes are carried on an endless belt with powerful streams of water thrown upon the dishes from above and from below, as they pass through the machine. Speed and thoroughness are the claims made for the machine.

#### New York.

In the Metropolitan Hospital at Blackwell's Island, large structures are being built: a large pavilion for the care of tuberculous cases, a dormitory for male employees, a service building for the tuberculosis division, with a dining room with accommodations for seven hundred on the main floor and the kitchen on the floor above. Also a service building for the general hospital division with the kitchen again on the top floor. Another building to care for 150 children is also contemplated.

At the Bushwick Hospital, Brooklyn, in a new building now being erected, there is to be a so-called "smokeless tower" built close to the main building, but shut off from it by fire-proof doors to be used in case of fire.

#### Detroit.

At the Grace Hospital, a service building for housing 100 employees is under construction. A special feature here will be the recreation rooms and roof garden.

A convalescent home or annex is being equipped three and one-half miles from the main hospital building by utilizing buildings formerly used as a sanatorium. Special attention is being paid to hydrotherapy, rest rooms, out-of-door sleeping porches, etc.

#### New York.

At the German Hospital a ten-story building is being erected for the care of private patients with especial attention being paid to the therapeutic department.

## Boston.

At the N.E. Baptist Hospital, a new bungalow, affording accommodations for ten private patients and an attractive lounging room for convalescents has been equipped. With the proceeds of a large gift recently received, they expect to have a fire-proof building, retaining in its design the home look and the various out-of-doors features which have specially distinguished their present hospital.

At the Massachusetts General Hospital, an addition to their nurses' home with accommodations for about one hundred nurses has recently been completed. This is a fire-proof building and has some very attractive features that you will doubtless see.

At the McLean Hospital, several bathrooms have been fitted up with continuous baths for excited patients. Why should not the same equipment be supplied to general hospitals for the treatment of the many cases of alcoholism, etc., that come to them?

At the Boston City Hospital new Murphy automatic stokers have been installed in their large power house.

On the second story of the Orthopedic Dispensary of the Robert Gurner Hospital for Children, Baltimore, is a babies' ward, one-half of which has a glass roof and sides, with the glass roof painted so as to mitigate the glare. The other half of this ward has only south windows with ordinary ceiling of plaster, but no glass sides or roof. The first part with glass skylight is used for the older infants who can sit up, and who are not subject to the overhead glare of light. In the infants' ward the beds are placed in the middle of the ward by twos, with the foot ends coming together, enabling the nurse to get at three sides of the crib with passage-way on the sides and with the avoidance of draughts.

The Children's Hospital of Boston, located near the Harvard Medical School and the Peter Brent Brigham Hospital, is now in progress of construction and I am told can be seen by such members as are interested.

Because of the lack of means only part of this plant is being built as permanent structures. The balance as now built being intended only for temporary use



until such time in the future as their means will allow them to build the permanent structures.

As now planned it will have a capacity of 132 beds divided into small units. On the first floor, in a typical ward building, there are two wards of ten beds each, plus one isolation room. A nurse sitting at her desk in the centre of these groups of rooms can see every bed. Each of these units has its own service and toilet rooms and if it should be necessary to isolate the patients in one unit, it can be readily done. There are extensive piazzas on both north and south sides. At the east end of one and the west end of the other of these typical wards are solaria enclosed with glass. Along the south side of the piazza, which is fifteen feet wide and which runs along the south side of the building, are covered shelters open on all sides under which patients can be placed in case of storm or to avoid the direct rays of the sun in summer.

There are two typical ward buildings in which two wards are superimposed and with each ward having a Monitor roof for ventilation purposes as unusual and are worth seeing. The ward buildings are heated by direct steam and the main building by indirect steam.

Besides their large amphitheatre operating room, there are three small operating rooms and a plaster room with galleries for a limited number of students placed between the two groups of operating rooms so that the work going on in either room is visible to the students. In front of each of the students is a glass screen, three feet six inches high, inclined at an angle of 45 degrees cutting off to a practical extent the spectator from the field of the operation. In their operating rooms the floors are to be of Terrazzo, and of Asphalt in their plaster and ward toilet rooms.

Adjacent to the Harvard Medical School buildings are the Peter Brent Brigham and the Children's Hospitals already referred to, the House of the Good Samaritan, the Collins P. Huntington Memorial Hospital for research work and the Thomas Rotch Infant's Hospital, now in construction. Near by are the Robert Brigham Hospital for chronic and incurable patients; the Baptist Hospital, Harvard Dental School and the Forsythe Dental Infirmary, the whole making an un-

usual group of buildings in close touch with a medical teaching centre.

At the new Cincinnati Hospital, the most notable departure of architecture in the construction is that the ward buildings are in two rows running east and west. These buildings do not face each other, as they deemed it advisable to have the sun parlors face toward the south in all the ward buildings.

The roof wards are also on a larger scale than any in this country, in that each roof ward has a complete ward kitchen, toilet, etc., in connection with it. The clothes chutes are unique in that they are provided with means for flushing them. In the large operating amphitheatre, there is a very extensive system of ventilation by taking the air out at the top. In the large amphitheatre in the pathological building where post mortems will be held, the air is removed below the post mortem table. In the service building, there will be a large vat for the pasteurizing, chilling and the storage of their entire milk supply. Another very important feature in this hospital, is the admitting department, where there are two wards, one for men, and one for women provided, so that in the event of patients being admitted after 8 o'clock at night, they can be kept in this ward until morning, rendering it unnecessary to send them to the wards and disturbing the ward patients. Provisions have also been made in this building to take care of sun-stroke and poison cases.

The X-ray department has been so planned, that one X-ray machine can be made to serve in two different rooms.

In the paint shop there will be a hot room built, for the baking on or quick drying of enamel painted beds, etc. They intend to construct the tops of the nurses' tables in the diet kitchen either of Monell metal or Benedict nickel. The entire surgical building will be piped for Nitrous Oxide gas.

At the Rochester General Hospital, the general office stands out in the open like a hotel office. The superintendent's office connects with this office and also with the hall. Other rooms on the first floor are the doctors' offices, the training school office, reception and waiting rooms. One waiting room is a large alcove

fitted like a railway station with benches divided into six seats each; this division prevents lying and lounging and general appearances are improved thereby. The women employees have a sitting room and a laundry in the basement of this building, and the men have a smoking room.

At the New York Orthopedic Hospital they are planning to make the country branch the main part of the institution.

At the New York Postgraduate Hospital the fifty private rooms placed in upper stories of their tower section seem to be popular and successful.

The Cook County Hospital is being reconstructed and at present an administration building, two wings, a psychopathic ward and a tuberculosis hospital are being erected. It is expected that a new hospital accommodating 4,000 to 5,000 patients and costing about \$10,000,000 will eventually replace the buildings now used.

At Oak Forrest, Ill., a new infectious disease hospital in which isolation is provided by the architect and made practically automatic, is being planned.

Dr. Hornsby is acting as consultant in both of these works.

At St. Luke's, New York, the X-Ray laboratory, in building a year ago is in use and is very satisfactory, adjacent to which is a pyelography room, so that patients X-rayed for cystoscopic examination will not have to be transported any distance, as little time will lapse between the insertion of the cystoscope and the Roentgen ray examination.

### The Care of Contagious Diseases.

Much work is being done in several cities in this line of work and many of them are following or adapting the methods first used at the Pasteur Hospital in Paris and first introduced, so far as I know, in this country at the City Hospital, Providence, R.I. The idea being (as Dr. Richardson of the Providence City Hospital so well expresses it) that "the sources of contagion are the children themselves. These are either carriers of the disease in question or else are suffering from some mild unrecognized form of disease."



Dr. Richardson lays great stress on the necessity in a general hospital for the care of children, of a detention ward into which children should pass before being admitted into the general wards. In an active service where children stay on an average of three weeks, accommodations should be afforded for one-third the number of those cared for in such an admitting department.

In hospitals for the care of contagious diseases, aseptic nursing and sufficient isolation rooms for the care of patients whose diseases have not been fully diagnosed and for patients with mixed infections, mean much to the administration and to the patients.

At the Philadelphia Hospital for contagious diseases, part of a new wing caring for one hundred diphtheria patients has been completed and \$250,000.00 have been appropriated for the completion of this unusually large hospital given up exclusively to the care of patients ill with contagious diseases. When completed, it is expected to meet the needs of the city for some years in the future.

At the University Hospital, Ann Arbor, a ward for contagious diseases in which different contagious diseases are to be treated is to be built, somewhat along the lines of the observation ward of the Providence City Hospital.

In remodelling kitchens with white tile on floor, all walls and woodwork are painted white with much improvement in looks, it is said.

Kendall Taylor & Co., of this city, who have been identified with hospital work for some time, recommend the use of iron or metal door frames and metal doors with fireproof floors. Terrazzo dadoes formed on the walls in a manner similar to that used in laying Terrazzo floors, is recommended, thus obviating cracks, and a surface flush with adjoining plaster walls.

They speak of a sheet metal base or cove that can be used with linoleum floors.

They recommend insulating metal vent or heating flues with non-conducting materials such as plaster or Terra Cotta block to prevent sound from being transmitted.

They are recommending that all metal that requires polishing be eliminated, and that all supply and waste pipes, especially to bath tubs, be made larger; that drinking fountains should be supplied nearer the patients, than in the ward kitchens where they are usually found.

In New York the trustees of the New York and Presbyterian Hospitals are considering tentative plans for building new structures to be located in different parts of the city.

At the Harper Hospital, Detroit, the "J. L. Hudson Memorial" building is being completed and will accommodate 180 patients.

This building has six stories and is of fireproof brick construction. The floors are Terrazzo, with the exception of the corridors and wards which have a six-foot inlaid strip of rubber tile running through the centre.

Special features of this building are sound-proof walls and an air washer provided to wash all air forced into the building, making it dust proof.

At the Detroit General Hospital, work is still in progress in the constructing of this broadly laid out plant.

At the Winnipeg General Hospital, a large addition, comprising an administration building and two wings in which the chief features are the small wards, a large sun gallery and a roof garden for the fresh air treatment is being constructed.

At the Vancouver General Hospital, a fine power and laundry plant has been built. In the laundry, a chief feature is the amount of light obtained by using several skylights. In the power house is installed an oil consuming plant.

The new Toronto General Hospital is nearly complete and is being occupied.

It is built especially to serve the needs of medical education, and is a university hospital in the true sense of the term.

There are 610 beds, 150 of which will be for private and semi-private patients.

Each floor of the hospital is devoted to a special service, with all the necessary and special rooms and appliances needed for carrying on the work of that special department.

As was stated in the beginning of this paper, hospital construction is a big subject, and what has been presented here, is the gist of the reports of new work done in some of the larger hospitals.

DR. F. A. WASHBURN: I am sure that I express the sentiment of the Association when I thank Dr. Peters for his paper which must have meant to him a very vast amount of work.

Those who are interested or still feel fresh enough to go about the hospital will find guides outside the door. The only thing new is the Nurses' Home which is in process of construction and I will go across there with those who are interested to go.

This meeting is adjourned.

## SECTION OF SMALL HOSPITALS.

The meeting was called to order at 10 a.m. in the Copley-Plaza Hotel, the Secretary, Dr. J. N. E. Brown, presiding.

The Secretary stated that Miss Mabel Morrison, Vice-President, who was to have presided, was unable to be present.



## Section of Small Hospitals.

### HOW THE SMALL HOSPITALS MAY BE MADE SELF-SUPPORTING.

BY G. W. OLSON,

Supt. The Swedish Hospital, Minneapolis, Minn.

It is less than two years since the writer gave up a promising business career to take the superintendency of a hospital of which he had been a trustee for a number of years. Some of his business friends merely smiled contemptuously, others expressed their scorn in strong terms of language. They were unanimous in declaring their pity for a man who had so far lost his sense of self-preservation as to give up a vocation in which he could always feel assured of bread and butter for his family and himself "without the leave of any man," to take up a line of work which in the minds of many bright business men today is considered commercially unsound and is looked upon at best as a tolerable form of mendicancy.

The hospital business—not being a professional man, I am prone to look upon it as a business, and my subject further leads me to take this view of it—the hospital business is not one that attracts capital, commands credit, or receives recognition in the commercial circles of the community. Why this is so, I cannot understand. It seems to me that the business of housing and providing for the wants of the sick is just as legitimate a business as that of housing and providing for the wants of the well, and should be regarded just as much a service to be paid for if not more so. And yet it is a fact, that while a good hotel is looked upon as a good business investment for the owner and its patrons cheerfully pay for its service a price calculated on a profit-making basis, a hospital, no matter how good, is classed as a poor business proposition and its service if paid for at all is paid for grudgingly at a low rate and valued at less.

There must be some reason for this. Perhaps it is that people have been taught for ages that sickness is a

form of punishment for sin. And people cling stubbornly to the notion that punishment should be inflicted at least without cash outlay to the recipient. No man pays a weekly rate in the house of correction, so why should he pay in the hospital? It must be largely on this theory that the governments of Europe and the municipalities of our own country are building gigantic establishments for the indiscriminate free care of the sick. People are learning to have little or no care about the days of sickness which are almost certain to come in the lives of all humans. They are allowed to gain the impression that they may spend their money indiscriminately in the "pursuit of happiness," which in the modern interpretation means pleasures and incidentally impaired health and disease; they "should worry"—the state or municipality will take care of them free of charge when the inevitable day of illness arrives. of course, this grace does not extend to the industrious taxpayer, who builds and maintains these free institutions. When he is sick, he must go to the voluntary hospital, where a charge is made for the service. Reflecting on this, it is not to be wondered at, if he finds it galling when he is asked to pay for service which the thoughtless, the reckless, the thriftless, as well as also the luckless, have thrust upon them free of charge.

In seeking the reasons for the slight regard in which hospitals are held as business enterprises among business men and the public in general, is it not probable that one of them is the fact that so few hospitals are really self-supporting? Self-support is an important consideration in winning both self-respect and the respect of others. Critics of our profession are very free in their comments upon what they term the unbusinesslike manner in which most institutions for the care of the sick are conducted. They point to our possessions in real estate and equipment—which very often have been given to us—to the endowments and current donations with which they find some of us showered, to the liberal rates which we are supposed to collect from our pay patients; and then they confront us with a long list of unpaid bills for supplies and repairs, a considerable deficit in the year's operating account, an inadequate and underpaid working force, charges of failure to return any interest on the capital

which our property represents or even to maintain its up-keep. Curbing our sentiment of so materialistic a view of our noble work, we point with pride to our report of the charity dispensed by our institution, cleanse our hands of all taint of commercialism and proclaim fervently our good intentions to labor incessantly for the sick and suffering of all mankind. To which Mr. Business Man is likely to reply that our whole expenditure for charity does not equal five per cent. on the capital invested in our enterprise; and as to our good intentions, he will remind us that we are simply furnishing paving material for certain uninhabitable but densely populated regions.

Whether or not it is desirable or necessary that a hospital should be self-supporting, is a question quite apart from my subject and I shall not attempt to discuss it. Certain it is, that in the case of the hospital founded mainly for scientific research and educational work it is impossible, no matter how desirable; and in the case of the state or municipal hospital and the heavily endowed charity hospital it is not necessary. But I take it for granted that to the great majority of the hospitals represented at this session for the smaller hospitals, the question of sustenance is a vital one and a condition of self-support both desirable and necessary. How, then, can this desirable condition be attained?

The wise doctor, who earnestly wishes to make his patient well, will first try to find out what made him unwell. So let us first try to learn why so many of the smaller hospitals are not self-supporting. I will name some of the causes as they appear to me:—

1. The traditional unwillingness of the public, already alluded to in the opening of this discourse, to pay for hospital service.

2. The severe and unfair competition of the hospitals maintained by public taxation and the charity hospitals maintained by private benevolence, which deliberately dispense service and supplies to pay patients at less than cost and very often give free service to patients who can well afford to pay.

3. The doubtful good fortune which befalls even many of the smaller hospitals, of being "born rich."



4. The vainglorious ambition which seizes many hospital boards and building committees, like the young mother's fond ambitions for her first-born, to go far beyond their means in rearing and equipping their young progeny after the manner of the millionaires on yonder hill.

5. The altogether laudable and worthy aspirations of many small hospitals to achieve fame as philanthropic institutions.

6. Faulty organization, such as too broad or too narrow charter or organic act, with unwise provisions as to Board of Managers, Staff, authority and duties of the executive, etc.

7. Last but not least we have the failure of hospitals, individually and collectively, to give due attention to the development of the business side of hospital operation, particularly the *source of revenue*.

Let us now briefly analyze the above causes and see what may be done to remove them or to remedy their defects.

1. The existing aversion to hospitals and especially to the payment of hospital bills is the result of inherent prejudice traceable to the days when hospitals and almshouses were inseparable. It is a condition which, fortunately, is fast disappearing as people are becoming better educated to the true function of the present-day hospital and the real value of its service. Our Association can do much to further hasten the complete obliteration of this cause.

2. The second cause named—the abuse by the public of the charity hospitals—is one that concerns these institutions quite as much as it does us who represent the voluntary or semi-public hospitals. And it is a hopeful sign, which promises the early removal of this cause, that these hospitals are themselves taking up in earnest the matter of curbing the abuses to which they are being subjected. Let us hope that they will pursue their efforts to a successful conclusion. If they can then also be induced to adopt a scale of rates for their pay patients which will be commercially sound and just, then we shall have little to complain of in the competition offered by these hospitals. Trustees of charity hospitals should wake up to the fact that it is

a violation of the trust reposed in them, in fact a misuse of trust funds, to dispense service and supplies at less than cost unless it be done for objects of charity. Tax-payers are waking up to face this question, and I think we may look for radical reforms soon in the methods of conducting the business of city and county hospitals, which at present are taking pay patients who can afford to pay all that the service costs, at rates which involve a mulcting of the public treasury in large amounts annually.

I cannot refrain from calling attention in this connection, to an abuse which is practiced through the municipal hospitals in the large cities and which is particularly injurious and unjust to the smaller hospitals. If you enter one of the large city hospitals and inquire into the matter, you will find that a very large percentage of its patients are there as a result of accidents of one kind or another. And if you inquire further into the history of individual cases, you will find that a great many of them are so-called liability cases: They have claim upon somebody as a result of their injuries, and if you probe deep enough you are likely to find that their doctor is or will be paid by an insurance company or other corporation or individual for his services, and when the patient is out of the hospital he expects to recover by suit or settlement, compensation for his injuries, sometimes in very large sums. Now these cases are treated free by the hospital, because the patient himself is often without visible means. The resulting saving of hospital expense to him invariably redounds to the advantage of the liability insurance company, which thus profits at the taxpayers' expense. My personal observations lead me to believe that this form of abuse of public hospitals is quite extensive. That it is grossly unjust to the smaller hospitals, who ought by every right to have this business at living rates, is apparent to everyone. The small hospitals located in cities where municipal hospitals are maintained should bestir themselves and vigilantly fight hospital abuses of all kinds, but this kind in particular. Let the taxpayer know what is being done with his money. And let the doctor who is not above using his influence to secure admission to the city hospital to some patient of moderate means in

order that he may be sure that there will be something left to pay his fee, understand that he is being watched.

May we not hope that the hospitals maintained by public taxation will eventually go out of the pay patient business altogether and apply stringently the test of qualifications to the charity patients admitted. Municipal hospitals are compulsory charity hospitals, and no one should be allowed to accept charity who is not in need of it. Otherwise sweet charity becomes a pauperizing factor in the community.

3. The third cause, that of being "born rich," is one that affects hospitals precisely as it does individuals. It is conducive to extravagance, looseness in business methods, and tends to produce a surfeit of eleemosynary effort that will make self-support, in the leaner years that are likely to come, doubly difficult.

4. Closely related to the foregoing, we find the fourth cause: The over-reaching ambition of the builders. This is especially active where hospitals are started under the stress of great enthusiasm due either to joy over a sudden and unexpected bequest or a spasmodic outburst of local civic pride. The evil effects brought on by this not uncommon cause is evidenced in the many institutions which we find having a magnificent building and costly equipment far in excess of the needs of the community served, but with little or no commercial credit and with both hands outstretched in solicitation of aid from kindhearted people, that the institution may not be forced to close its doors. Many builders of small hospitals today are altogether too prone to pattern after the big, powerful, heavily endowed or publicly erected hospitals. It is evident from the experience of many that in order to insure self-support, or in other words, to make the business pay, some sane proportion must exist between the capital put into the construction and equipment of the hospital and its earning capacity or number and class of beds. I believe that a good hospital can be built and equipped at a cost of from one thousand to fifteen hundred dollars per bed, and I believe further that just as good service can be given the patient in such an hospital as in some of those which are now being built with an expenditure of from three thousand to four thousand dollars per bed.



The fifth cause named in the list of difficulties which beset the smaller hospitals is one which I fear I cannot discuss without revealing some of my own weaknesses. And if in discussing it frankly, as I must, I hold up a mirror in which we see ourselves, some of us as we are and others perhaps distorted, I trust you will not take me too severely to account for the rudeness.

Most of us hospital executives are naturally tender-hearted and sympathetic. It is these qualities that have led us into the work. And it is these qualities, and not much else, which keeps us in the work. We are natural born philanthropists, most of us without the means, however, to exercise our natural bent except in the matter of our time and our energies. We are generous to a fault; so generous that we will often give away even that which is not ours.

The fact of the matter is that most of us superintendents of small hospitals are a lot of "mollycoddles"—pardon the term—when it comes to differentiating between business and charity. So many of us have our wishbone located where our backbone ought to be. Maybe that's why we remain superintendents of small hospitals. We can look on complacently while the doctor comes into our hospital and in an hour or less performs a service for which he receives as much as most of us receive for thirty days of hard work during 12 to 18 hours of each day. And then we can listen to the complaints of the patient from whom the doctor extracted that fee, of the terrible expense of a siege in the hospital, and in our anxiety to please and our overwhelming pity for the sick and suffering we refigure our bill down to the lowest possible point, leave out several items which we know the patient has received—and which we also know cost us money—and then discount the whole ten to twenty-five per cent.; or perhaps we must wait for our money until the account is quite old and then we gladly accept fifty per cent. in settlement. In the meantime our bills go right on piling up and we tremble at the thought of what the surgeon, who can come into our hospital and make five hundred dollars in one morning, will say when he finds the supply of gauze curtailed because our last order is held up pending a payment on account.

Isn't this the experience of many, and what lesson does it teach us? Sisters and brothers in a noble profession, we must *be just before we are generous*. Just to our little institution, which is entitled to receive every dollar it earns; just to its sponsors, who should not be called upon to contribute to its running expenses; just to its patients, who should not have a portion of charity thrust upon them and still be allowed to believe that they have paid for everything received; just to our creditors; and, finally, just to ourselves and our subordinates in the matter of wages, working hours and living accommodations.

The sixth reason assigned for the failure of hospitals to provide their own sustenance has to do with their organization and provisions for government. This is a factor of greater economic importance than is generally recognized. A hospital founded through the benefaction of one man or woman, with a small and exclusive self-perpetuating board of managers, can hardly hope to reach the point where its receipts from service and supplies sold will equal its expenditures. Any hospital founded on large benefactions and showered with gifts in the days of its beginning will find it exceedingly difficult to establish itself on a business basis. Too much will be expected and demanded from such an hospital in the way of free service, and the duty to render such service will always weigh heavily on the management of the hospital, making it difficult to establish and enforce living rates. The community served by such an hospital, however, should be enlightened to the fact that a money value must be placed on the free work, exactly the same as on the paid work, and that the most that can reasonably be expected from the institution in the way of free work is an amount equivalent to a commercial rate of interest on the capital represented by the hospital property plus any moneys which may be derived from interest on endowments or from current donations. And the public should further understand that in order to render such free service, the hospital must be allowed to collect for its paid service not only what that service actually costs, but a sufficient margin above that to meet the cost of the charity work.

A common type of hospital organization is the church hospital owned and governed by a church conference or

synod. These hospitals are generally successful, if we may judge from the face of their financial reports. But if we stop to analyze these reports, we will find in the case of many of them that the free work performed has not amounted to as much as the church collections and other gifts received, indicating that the paid work has been carried on at an actual loss and no interest whatever returned to the large capital placed in the hospital property. The writer has in mind one hospital of this type which possesses buildings and equipment costing over two hundred thousand dollars. The last annual statement of this hospital shows free work done to an amount approximately balancing the church collections and other gifts received for charity purposes. What has the two hundred thousand dollar investment returned in this case? Certain it is, that not many of the pay patients of this hospital—and it has a large number annually—are going to return thanks for the service which they received at less than cost, or congratulate themselves upon their good fortune of having unknowingly been the objects of charity. Looking into the organization of this hospital, we find that it is governed by a board of sixty or more members elected by the church conference controlling it, and these members are scattered over a large section of country.

It is a common fault with church hospitals to have large and scattered boards, composed to a great extent of clergymen and laymen of very benevolent tendencies, whose influence is more often used to obtain for some friend and neighbor special favors and rates at the hospital than to help increase its revenues. Better, however, to have the hospital governed by clergymen than by a coterie of doctors. No more hopeless situation can be pictured than a hospital, supposedly a general hospital, dominated by a clique of physicians, whether they constitute its board or its staff. Imagine a church or community hospital thus ruled, with its doors tightly closed against all the doctors not in the sacred circle, and this same impregnable circle not assuming a particle of responsibility or the slightest care for the financial success or failure of the hospital. The great surgeon in the group goes south in winter and abroad in summer, and the great medicine man follows closely on his heels.



Bright and industrious young doctors are thriving in your town and they knock at your door for admission to their patients; but no, the rules of your staff and the "ethics" of the institution must be observed; the cobwebs continue to grow in your doorways and only the occasional calls of your patient creditors enliven your languid existence.

I am not prepared to prescribe the ideal form of organization. But I believe that the community hospital, born of a genuine community need, nurtured by a general community interest and supported by a loyal community patronage, when blessed with simple laws and wise management, comes very near being the ideal. To illustrate, let me tell you briefly the story of a remarkably successful hospital—The Swedish Hospital of Minneapolis, Minnesota. This hospital was started fifteen years ago in an old rented dwelling, furnished and equipped in the simplest manner to accommodate about twenty-five patients. Today this hospital occupies modern buildings with a capacity of 125 beds, the net worth of its property above all indebtedness being in excess of one hundred and fifty thousand dollars. And this has been accomplished with less than ten thousand dollars received in any other form than as payment for services rendered.

The organization of this hospital is exceedingly simple and it is one that can be worked out successfully in any community. A few men—clergymen, doctors and laymen—interested in founding a hospital, met and formed an association under the state laws governing corporations for benevolent purposes. It was provided in the charter that there should be no capital stock or shares; the corporation should consist of two classes of members: Annual members paying one dollar each year and having the right to vote for trustees or themselves become trustees; life members paying twenty-five dollars for the same privilege during their natural life and in addition being entitled to hospital care to the amount of twenty-five dollars in case of sickness, without forfeiting any privilege of membership. By a later provision these life memberships have been made perpetual, so that a member may designate some person to succeed him upon his death, subject to approval

by the board of trustees, or failing to make such designation the board may confer the vacant membership upon any person whom they see fit. This insures absolutely the permanency of the membership, which at present numbers about two hundred. The hospital benefit conveyed by a life membership is, however, only available by the original holder personally and on his death this liability upon the hospital lapses. The constitution of the corporation provides for a board of trustees of twelve men, four of whom are selected each year at the annual meeting of the corporation and serve for three years. This board elects its own officers, meets regularly once a month and has full authority to transact any and all business incident to the operation of the hospital. The board subdivides itself into committees, such as an executive committee which is also the finance committee, a training school committee which passes on all applications for admission to the training school, an auditing committee which goes over the bills each month, a house committee which makes periodical inspection of the hospital and dormitories, and a charity committee which rules on all applications for free beds or aid from the hospital's charity fund. The board engages the superintendent and clothes him with wide authority and corresponding responsibility in the conduct of the internal affairs of the hospital. All other employees are hired by him or upon his recommendation, and he has full authority to dismiss any employe for cause which he deems sufficient. He makes all purchases necessary for the operation and maintenance of the hospital, and it is only when extensive improvements, building operations or the purchase of real estate is concerned that the board assumes a part in the transaction. He is given full authority to use his own judgment and discretion in the admission of patients, in the permission of physicians not on the staff to introduce patients, in the application and enforcement of the rates and rules of the hospital, and in the collection of delinquent patients' accounts or the settlement of any dispute arising in the ordinary course of business.

The staff of this hospital, consisting at the present time of twenty-eight active men, is appointed annually by the board. At the beginning of each year, the list is

gone over in executive session and any staff member who has displayed disloyalty to the hospital or in any manner proven himself unworthy is dropped. It is needless to say that under these conditions staff men are as a rule very loyal. The board, through its superintendent, is absolutely the judge as to who may or may not treat patients in the hospital. Its doors are open to any reputable practitioner. Recently, however, it has been necessary, for lack of room, to confine admission to patients of staff members only. But as soon as needed additions can be built, the democratic character of the hospital will be restored, for its founders and sponsors believe firmly that the community is better served by an open hospital than by one run on the closed staff plan.

The Swedish Hospital form of organization is one that may be employed anywhere with better chances of success than any other plan I know of. It permits everyone in the community who is at all interested in the work of building up a hospital, to have a part in it, no matter what his social or financial station may be, so long as he is a person of good character. It is a mistake to think that only the rich can or ought to be interested in this work. The poor man has nothing but contempt for the enterprises, no matter how benevolent, which the rich man condescendingly establishes for him without his asking. Take the great mass of the people into your confidence, and if your enterprise can be helped at all by public support, it will be a success. The religious interest need not be overlooked in the working out of this plan. Often it is the churches which take the initiative in a hospital campaign, and such was the case in the establishment of the Swedish Hospital. But there were people of several different denominations as well as persons of no church affiliation. The provision was agreed upon that at least seven of the twelve men constituting the board of trustees must be members in good standing of some evangelical church of America, but not more than five may belong to the same denomination, insuring freedom from denominational control.

The Swedish Hospital plan of foundation for a hospital is conducive to self-support, because it compels it. The campaign for members in the hospital corporation



will, if successful, yield barely enough money to purchase the ground for a modest beginning. Funds for the erection of the building must be borrowed, and this requires the pledging of the individual credit of the trustees. The necessity for such a credit compels the choice of responsible business men as trustees, men of a character that would insure success to any worthy enterprise.

But we have yet to consider the seventh, and most important, in our list of causes for the financial difficulties of the smaller hospitals. This is *the universal failure of hospitals to give due attention to the earning capacity or revenue sources of their business.*

The evolution of the hospital from the primitive "krankenhaus" of a century ago to the modern institution for the care of the sick is truly wonderful. Insofar as this progress has been made solely with a view to the attainment of scientific results, or for the purpose of discharging most effectively organized society's obligation to its helpless wards, without the need of much thought as to the sources of revenue for its support, it has been perfect. But, when those members of society who neither wished to submit themselves as subjects for study nor could qualify as paupers decided that they also wanted the advantages of hospital service, and in consequence, hospital operation of necessity became more or less commercialized, the fleet steed of scientific progress was hitched with a horse of an exceedingly wary disposition. The economic problem at once assumed importance and with it many became paramount. The American Hospital Association was organized and adopted "Economy in Hospital Management" as part of its slogan. The problem has been considered at every meeting of the Association, I believe, and many are the valuable contributions which have been made towards its solution at these meetings. But I fear that our efforts in the past have been altogether too closely patterned after that parsimonious farmer who claimed to have succeeded in weaning his horse from the habit of eating and would have trained him to get along without drink, too, if the poor "critter" had only lived long enough. We have made great strides in the direction of keeping down the per capita cost of food and medicine; in

increasing the efficiency of our service, while reducing the number and wages of our employees; and if there has been any tendency in our Association towards "unionism" in the matter of our own wages, it has certainly not found expression.

The primary source of revenue of a hospital is its beds, with the attendant general nursing and feeding. For this service a daily or weekly rate is charged, varying in amount according to class of accommodation, which generally means merely the difference in location of beds and surrounding appointments.

In making up a schedule of rates for bed, board and nursing in your hospital, you should as far as possible be governed entirely by your costs—cost of building and equipment and cost of operation. And in apportioning this cost according to the number of your beds, don't lose sight of the fact that those beds are likely to be vacant a good portion of the time. The average vacancy in our hospital is twenty-five per cent—and at that we are overcrowded during three or four months out of the twelve. But we must keep our doors open at all times, every bed in readiness every day and night, the regular quota of nurses and employees on duty the year round; the fixed expense goes right on at practically the same rate whether we are crowded or not. If there are already hospitals in your community, the precedent set by these in the matter of rates may have to be reckoned with in the beginning. But if you find after a trial that their rates would mean your ruin, don't give up in despair, but go frankly to your colleagues, and it is ten chances to one that you will find them in the same predicament as you are in. The course to be pursued is then plain.

When we opened our hospital in Minneapolis fifteen years ago, the established ward rates in the hospitals of our city was six dollars a week. We tried this rate, but soon found it inadequate. We called on the other hospitals and found that they didn't like it any better than we did, and so the rate was raised all around to seven dollars. Twice this performance has been repeated without even a meeting of hospital executives to discuss the matter, and today the nine or ten general

hospitals of our city are getting nine dollars per week for their ward beds.

The rates charged for double or single rooms are largely a matter of location and equipment of rooms, but they must bear some proportion to the ward rate, which is the basic rate. In our hospital we have double rooms at ten to fifteen dollars per week per bed, and single rooms at twelve to thirty-five dollars per week.

It is doubtful if there is any small general hospital, conducting a training school and maintaining the ordinary medical and surgical service and equipment as required by the profession and the public today, which can care for its patients at less than two dollars a day. If the hospital has no training school, but must employ a number of salaried graduate nurses, the cost will run much higher. We know, therefore, that even at nine dollars per week we are losing money on our ward service. This loss, however, we are able to recoup in our private rooms, especially in the higher priced rooms. Every small hospital should have as many of these rooms as its clientele can possibly support. They occupy but little more building space than the cheaper rooms, and all that is necessary to obtain practically double the rate for them is to equip them with a bath and put an additional hundred dollars into the furnishings. This added cost will be returned several times in a single year, giving you a good source from which to cover your losses in the wards and from which you may also obtain a surplus for free work, or for necessary improvements and extensions of your institution.

But bed, board and nursing is not all that your hospital has to sell, nor is it all that the average patient wants to buy. Every hospital has special departments and services for which special charges are or should be made. And these charges should bear no proportion to the weekly rate paid by the patient, but should be alike to all and figured frankly on a basis of cost with a liberal margin of profit. If such services as the hospital renders in its operating rooms, its pathological laboratory, its X-Ray laboratory, or even in its ordinary department of nursing, could be measured according to their real value, who would limit the price? Certainly



not the public, so why should we, when the matter is left to us, set it so low that our insititutions with difficulty support themselves?

The regular weekly or daily rates quoted by a hospital should properly not include anything more than bed, board and general routine nursing and medication. It is manifestly unfair to fix a certain rate and then say, "This includes all medicines and dressings," or "This includes everything," as the fiction issued by some "sanatariums" reads. Some of your patients will have a great deal of medicine, others practically none; and in these days of serums and specifics of all kinds, the medicine bill often exceeds the entire weekly hospital rate. It is also unfair, both to yourself and to the patient, to fix a certain fee for operating room or laboratory service. No two cases in a day are alike either as to time or materials required; one may take only a half hour of your operating room and attendants and just a few yards of gauze, another two hours and two bolts of each respectively. So why should you gamble on it? It is certain that even if the patient feels that he is taking a chance, he doesn't want you to take any. And why shouldn't your ward patient pay just as much for operating room or laboratory service as your private room patient? Those of you who conduct hospitals in smaller communities know that the fairly well-to-do, especially among farmer folk, will often take a bed in the ward; and those of us who do business in the cities know that a great many of our ward patients are corporation cases. So where would be the justice or charity of charging less for the services named to ward patients?

I am not prepared to set up a schedule of rates by which any and all hospitals may do a profitable business, but to illustrate the method of charging which I consider just and the rates which in our case at least have proven sufficient for self-support, I will quote a few individual accounts taken at random from our patients' ledger.

Number One is the case of a carpenter who fell from a building and sustained a broken forearm and a dislocated hip. His bill reads:—

Ward at \$9.00 per week, 7 weeks, 6 days.....	\$70 80
Dressings .....	3 05
Medicines .....	1 45
Pathology .....	50
X-Ray Dept.—4 skiagraphs at \$5.00 .....	20 00
Crutches .....	1 25

Total ..... \$97 05

Examining the Dressing Room slips in this case, we find that the patient had two casts, some special splints, and bandage material and cotton which brought the total charges in this department to \$3.05. The medicine bill of \$1.45 is for a prescription, twice refilled, which the doctor gave the patient for some slight complaint not related to his injury. The pathology item of 50 cents is a fixed charge which the hospital makes for urinalyses in all cases. The X-Ray Department reports having skiagraphed the patient at two different times, two locations each time, making four negatives accepted and approved by the doctor. Five dollars is our minimum charge for one "picture" of an ordinary fracture case. From that the schedule rises to \$10, \$15 and even higher, depending on the character of the case. We find that even at these rates, we are doing this work considerably cheaper than the doctors who have similar apparatus in their offices. As a result, our staff members invariably go to the hospital for X-Ray work, even in minor and exploratory cases, where the patient does not remain for treatment. This department is therefore a source of considerable revenue to the hospital.

Number Two is an ordinary acute surgical case. This bill reads as follows:—

Room at \$18.00 per week, two weeks .....	\$36 00
Hospital nurse at \$15.00 per week, 1 week .....	15 00
Operating room .....	7 30
Anesthetist .....	2 00
Dressings .....	2 50
Medicines .....	1 65
Pathology .....	2 50

Total ..... \$66 95

The operating room charge of \$7.30 consists of the following items, which the supervising surgical nurse has entered on a blank much resembling a grocer's order slip: Operating room, \$3.50, (which is our minimum charge for one hour or less); anesthesia, 60c.; alcohol

and other disinfectants, 50c.; gauze, sutures, bandages and dressings, \$1.50; gowns, sheets, and towels soiled, 50c.; surgeon's gloves spoiled, one pair, 70c.; total, \$7.30. The hospital employs special trained anesthetizers and makes a charge of \$2.00 in each case for this service. The pathology in this case, amounting to \$2.50, consists of the routine 50c. charge for urinalyses and \$2.00 for a microscopic examination of a frozen section.

Patients very rarely complain of these charges as being unreasonable. Sometimes a knowing one will tell us that such and such a hospital charges just five dollars, no more and no less, for operating room service; but we have no trouble in convincing this person that it is just as unbusinesslike for a hospital to put a uniform price of five dollars on operating room service in each case as it would be for his or her grocer to put such a price on the supplies for any family's Sunday dinner, with the specifications for the dinner left to the cook. As to other special charges, such as dressings, medicines, laboratory and X-Ray service, any dissatisfied patient needs only to inquire of the different establishments dispensing such supplies or services to learn that the hospital is the cheapest place to buy them.

The more special services the hospital can offer to its staff and patients, the better it will serve both and the better will be its revenues. The time is fast approaching when all the various therapeutic agencies, such as baths in all their forms, temperature and light treatments, massages, etc., will all be centered under the roof of the modern hospital, accessible to the public at much lower rates than is now the case with each trying to build an institution around itself. When the legitimate general hospitals once take up this extension of their service to the people in earnest, it will mean the death-knell of the fake "cure" institutes which infest our land and dupe the ignorant and suffering with their pretenses to be masters of secret sciences.

My paper is already much too lengthy and I have said nothing of the part the training school might be made to play in the solution of our problem. I have purposely overlooked this factor. I am not favorable to the exploitation of the training school for financial gain. Of course, each pupil should be given a varied number of a varied kind of cases to nurse privately in the hos-



pital, and this service should be charged for at a rate of not less than ten dollars per week; we make it a rule to charge fifteen. And I look forward to the day when, for the pupil's own benefit, it will be the rule of training schools that each pupil must have a few weeks of private home nursing before her training can be called finished. And of course the hospital should charge for this service. Properly managed, the training school of even a small hospital can contribute a good deal towards the support of the institution, without any abuse of the curriculum.

But I hear someone ask: What about the charity and free work which we must do?

Let us all be reminded that our hospitals have no obligation to do free work unless they have received money for that purpose. Money given to the hospital for buildings and equipment is money invested and it should not be expected to yield any more in this form of investment than a fair commercial rate of interest. To this extent our hospital is obliged to do free work in return for any gift toward its erection or extension. Beyond that the public has no right to expect free service from the hospital. But when a community rears a hospital, it opens up a new avenue through which its benevolent people and people of means may perform more real charitable service than through any other path heretofore leading to the poor and needy in the community. It is the duty of the hospital to educate the people to a realization of its value as a powerful means for good among the poor, sick and suffering.

Let us come to a realization of the fact that the hospital can be nothing more nor less than the medium through which benevolent people may perform charitable service. The finest example of charity to the helpless sufferer is given us in the parable of the Good Samaritan. Preach that in your community. Put it into practice. Organize the women of your town into a hospital charity association; make it broad enough to include both the wife of the banker and the wife of the baker. Such an organization working in conjunction with our hospital in Minneapolis has expended over ten thousand dollars for the care of poor patients in the hospital during the few years of its existence. And the social service it has rendered in addition cannot be

measured in money. Go to the men in your community whom you know to have the means and induce them to become Good Samaritans. Follow up the cases in which they become interested and keep them informed. Soon you will find your charity cases a source of joy instead of worry, and your good men and women will rejoice with you. Not the least joyful will be your bookkeeper, who will be able to render a statement showing all bills paid, all patients' accounts closed and a comfortable balance in the bank at the close of the year. This will inspire confidence in your institution and you will soon find it rated not only at the bank as a good credit, but in the hearts of the people as a factor for good not excelled by anything in the community.

#### DISCUSSION.

CHAIRMAN: You have heard this very stimulating paper. It is now open for discussion.

DR. COOK (Natick, Mass.): I did not expect to open the discussion, but I do not like to have the time go without anyone saying anything. I am sure we all very greatly enjoyed this paper, we especially from the smaller hospitals. I took the opportunity at once of congratulating the reader and telling him that he had given me food for thought.

I have just two points I want to make now. One is the remedy, that we are indebted to for, I think in a large way, to President Roosevelt, nevertheless I think he gave us a most excellent solution of many questions, and that is publicity. I believe one great need in the securing of the support for small hospitals in smaller cities and towns is publicity. Make the public understand that it costs to run a hospital, get the public to understand that everything has to be paid for in a hospital, give them to understand that they are getting better care at lower rates than they can possibly get at home. They do not know that. Why, our hospital was opened in March, 1899, and yet I am surprised at the ignorance of many of the people of that town in regard to the financial situation of the hospital, and it represents simply all hospitals. They do not know that ward patients are receiving gratuitous service from physicians and surgeons. They suppose, many of them, that the physicians and surgeons are paid for the care of the ward patients. They ought to know that they are not. It is not a year since I had to tell an old-time resident of our town that those on the staff received nothing.

It may be of interest to know that a little account was kept for several years of the service at the rates that we received in Natick—and they are small rates—in dollars and cents, and perhaps I can best illustrate it in this way. We have a district

nurse association that was started almost the same month that our hospital was opened for service. One of my patients, one of the old residents of Natick, said to me one day, "Dr. Cook, I am raising some money for the District Nurses' Association, I thought perhaps you would like to contribute something." I said, "Deacon Wilson, the District Nurses' Association is a most excellent organization and doing most excellent work, but the physicians connected with our hospital are every one of them giving more to the poor patients than you will ever get in money from any layman. Do you think we ought to give money?" Then I made a computation, and without going into the detail of it I will tell you how it came out. Twelve Boston and Natick physicians and surgeons—I am including the Boston consulting surgeons—had given in gratuitous services at ward rates, that if they had collected money at the Natick rates for surgical operations and medical service for the number of years that it had been open, then about six years, if they had paid for that and had given that money to the District Nurses' Association, they would have been no poorer than they were then, but that District Nurses' Association would have received money enough to have paid its bills at \$900 a year for 25 years. That was the service that had been given by the physicians and surgeons. Now, they ought to know that. You say that it is a plea on behalf of the physicians and surgeons. No, it is not, but it is putting before them what the community is receiving. Then another thing. Many a patient is receiving for \$20 or \$25 a week, others for \$15 a week, what that same patient and the same nursing service and care rendered that patient at home, would cost the patient \$50 to \$75 a week, and yet they complain of hospital charges because they are so high, and when I have put those facts before them they have seen it in a new light.

The speaker alluded to the man who went down to Jericho and fell among thieves, and the kind friend who took him to an inn and told the inn-keeper to keep account of what he expended and "when I come again I will pay thee." That is all right, good friends, if that was a poor man, but I have wondered a good many times whether the person who received those services, although he was robbed then and there of all he had, had a bank account large enough so that in the end he could have paid for those services and whether he ever did or not.

MR. FOWLER (Supt., Vassar Bros.' Hospital, Poughkeepsie): There are a number of Vassar philanthropies in Poughkeepsie, all of which are attributed to Vassar College. This is an entirely distinct and separate institution.

I want to emphasize one point which the reader brought out, that the hospital should be a medium for philanthropic effort. The institution which I represent has the fortune, or misfortune, to be very largely endowed, so that the people of Poughkeepsie have no reason to participate in contributions to the carrying on of the work of the hospital, and I have been impressed very forcibly with the fact that it has paralyzed every bit of philanthropic effort in that community. I was once talking with an



eminent doctor in New York; I asked him what proportion of the moneys which carried on his institution were derived from the income on the endowment or investments. He said, "Twelve thousand dollars and our institution spends \$400,000 to carry on its work, and we wish we had not the twelve thousand, it is a stumbling block in the way of any philanthropy." It seems to me that is a point well worth enlarging upon and emphasizing, that the hospital affords a medium through which the philanthropic people in the community exercise their philanthropy, and the essential thing is, to arouse by publicity and in every way possible the need of the function of the Good Samaritan, that the individual still has some work to do in caring for the sick, and the hospital is a modern means or medium by which that work can be more effectively carried on.

CHAIRMAN: Are there not some others who would ask some questions, or take some further part in the discussion. The paper was bristling with points. You may have observed that Mr. Olson takes a different view with respect to the medical organization of the small hospital than was taken yesterday by the reader of one of the papers, in that he recommends the open hospital. I should like about twenty experiences from members present here as to how they are getting on with open hospitals, or how they are getting on with closed hospitals. We in the larger hospitals, especially those that are city hospitals, advocate the policy of a strictly closed hospital, while I believe in country places and smaller hospitals that is almost an impracticable thing to be carried out, and I should like very much to hear, and I think the rest of you would, some of your experiences on that point which Mr. Olson has raised.

MISS NETTIE B. JORDAN (Aurora, Ill.): I am from Illinois, and I want to say that the medical men of Chicago and some of the leaders in the State Medical Society undertook to have a closed surgical clique, in order that we would have staffs, simply a staff in each hospital that would do the operating, and they presented this to the State Medical Society and it fell flat. They undertook to put it through the State Legislature at a time when I was there, and it also fell flat there. I think in the small hospitals, that we must conduct them on open lines to all reputable physicians. Of course they may in large hospitals be able to find it to the advantage of the hospitals to have them closed, but they cannot do it in small hospitals. I represent a small hospital with thirty beds, and with three other hospitals in the city that gives us a competition that is keen, I am sure that we could not afford to have a closed staff, and most superintendents of small hospitals will testify that the work done by these men in smaller communities is creditable to any hospital. It was tried in Illinois to establish the practice of closed hospitals, so that we would have to send all surgical cases to Chicago or some other hospital in larger cities, but it did not pan out.

CHAIRMAN: The question of the open hospital—of how you raise money, or how you fail to raise it, is a very vital question with all of us.

MISS JORDAN: If I may be pardoned for speaking again, I think I made a record last year on finances. In our hospital last spring we were running short on our finances for the maintenance of our hospital, and our hospital board came to me and wanted me to explain why we would have a deficit there, and I explained to them that we had more wards than private rooms, and even though I was collecting 95 per cent. of all earnings, yet I was not able to make ends meet, so we put on a tag day—you all know what that means—and we were able to clear \$5,000 in one day above all expenses, so it was worth the trouble and we were then able to carry our deficit over a number of years. It was done by the aid of a great deal of publicity, and—the way I express myself—I get on the ground floor with all the newspapers and for two years I kept up a constant plea for new buildings, that the city needed a better hospital, kept this continuously before the public for two years, then we put on this publicity campaign, Mr. Bowen conducting it. We were able to receive pledges to the amount of \$16,000. There were 14,000 people that gave to the hospital, that means that we have 14,000 people that are interested in this hospital. Every one is saying to me, "When is our hospital going to be built?" That means that they are interested in that hospital, and though we have not an endowment, yet we have 14,000 people interested in the affairs of the hospital and anxious that we should stand at the top notch in the community in equipment and support of our hospital.

CHAIRMAN: Some more life stories, please.

DR. COOK: In Massachusetts the laws are such that hospitals owned or controlled by cities or towns, the cities can make an appropriation each year. There has also been a hospital founded by something like \$150,000 given to the town in its corporate capacity by trustees chosen by the town, one each year for seven years and they have full control of the hospital. The town can vote nothing in the way of regulation, that is, it can vote all it pleases, but cannot control, and when it has chosen its trustees its authority ends. Our chairman is a well posted lawyer, he has looked up the laws very carefully. We had difficulties, although we had an income from \$100,000 from funds for buildings, we let the fund accumulate and we erected our buildings substantially from the income and left the original sum. Nevertheless, we had to resort to various means which you all know about in your own experience until our chairman, a lawyer, looking up the laws carefully, found that the town could vote an appropriation each year, and so for the last few years we have had an annual appropriation of \$3,000 voted by the town, raised by taxation, and we have had no deficit since. That appropriation will have to be raised in the coming year, but that has been the solution for us. You say that does not arouse the same philanthropic spirit, perhaps not, but it does this, it makes people of means contribute who would not otherwise give us one cent. They are taxed for it, and they all contribute in our town now according to their tax list. That has been our solution, and other Massachusetts towns, I suspect, will do the same thing. I do not know how it will be in other states.

CHAIRMAN: Let us hear how it is in other states.

MISS JORDAN: We have a similar law in Illinois. I have been investigating this law and find that there is a possibility of this appropriation being cut off any year—the politicians can cut this appropriation off any year, and that takes away the definite income. I wonder if that is true in Massachusetts.

DR. COOK: That can be done any year, but what would be the result? It would hit the poor people, it would hit the people who are now receiving ward care for nothing. Just as soon as any hospital cannot pay its bills it must contract on its charity work, and I doubt if you can get any town to cut off the appropriation for any length of time, when they understand that they are hitting the poor people, not the people who can pay their bills.

MR. WHEELER (Worcester): There seems to be a little difference of opinion between Mr. Olson and Dr. Cook. Dr. Cook pleads for an appropriation from the town, and Mr. Olson thinks that a hospital supported by taxation should not receive pay patients. I quite sympathize with that idea. I think that the tax-supported hospital had better not look for support from private patients, I think things will be straighter and healthier with those two things separated, and whether Dr. Cook's plan of having an appropriation from the town or city is not even more enervating than a fund, an endowment for the hospital, I should think is a question. I represent an endowed hospital, so perhaps I am prejudiced, but it seems to me that a board of trustees that cannot manage an endowment and get over that difficulty is not clever. I think that an endowment is just as proper a form of support as a hospital can possibly have, and that somehow the board of trustees ought to make that appear right to the community.

In addition to that I just want to express my pleasure in the paper of Mr. Olson's. It seems to me healthy all through. There is no flaw in hospital management when you get it on a business basis, so that you can get out of it what selfishly and humanly and properly should come out of it. Then all your charity beyond that is all right, but have the thing founded on a business basis and not built for charity alone. I think that makes the thing more healthful.

MR. PALMER (Framingham): I want to congratulate the reader of the morning on his very excellent paper and I want a copy of his last report. I want to make two points. The first is that I think that a big endowment in small communities is not necessarily a blessing. I represent a hospital that has been running over twenty years with 75 beds. We started with nothing. We are not like the poor man who said he was born with nothing and he had the same when he died. After twenty years we have a building paid for, and we have the goodwill, or ought to have the perfect good will of the community in support of it. A big endowment leads the people to say, You have got an endowment, pay your bills. If the hospital is poor the people are very apt to say, "It is our hospital," and they



will go into their pockets on proper occasions and dig out the money to help carry it along.

The other point I want to make on Mr. Olson's paper is, I rejoice to hear him say that he has an open hospital. I have very strong and positive feelings on that question. Our hospital had a wonderful success, and I believe it was chiefly due to the fact that it was an open hospital and every physician was welcome to bring his patients and take care of them in the wards and in the private rooms. While the closed hospital and a clique, so termed here, may be the true and best policy for city and large hospitals, my experience and observation and conclusions from the thirty years I have been connected with a so-called small hospital is that the open hospital is the thing for the small hospital and that every doctor can feel free to take his patients and have the same care of them that he does in their home.

MISS HARTRY: I have been waiting for a number of years to hear just such a paper as we had this morning from my friend and neighbor, Mr. Olson, of Minneapolis. Each year when attending the convention, and, being an eastern woman, knowing something about the eastern closed hospitals, I have had several discussions with members of this Association who have asked me something about open hospitals, and it has seemed to some that an open hospital would be quite an impossible situation. The last speaker spoke of rejoicing to think that he had an open hospital. Sometimes we rejoice, those of us who are in open hospitals, and sometimes we do not. However, I want to say that the hospitals in the Middle West were organized in this way, and are operated as the hospitals of Minneapolis, the Swedish Hospital we have heard about this morning. Forty-two years ago St. Barnabas hospital in Minneapolis was organized, when the city was quite an infant. It has operated ever since and has been called an open hospital, that does not mean, however, that these hospitals do not have a staff. The majority of them, I think I may say, all of them have. For a number of years the men composing the staff of these open hospitals have been trying to close down, have been trying to shut out certain physicians, young physicians, and a little over a year ago we found ourselves in rather a peculiar situation. We had either to enlarge our staff and take in so many men that the staff would not mean anything, or we had to have an open hospital in reality. The board of trustees were unwilling to try such an experiment, and so they devised a scheme like this, they thought they would appoint three members of the board and three physicians and the superintendent who would compose a committee of seven, and to that committee should be given over the management of the hospital. This committee was appointed, but I think perhaps I may say it this morning, because you are in the minority, we could not seem to find three doctors who agreed on just the management, so that that idea was abandoned, and after considering the matter and holding numerous meetings, we decided to have an open hospital in reality, and so we have not had a staff since June of this year. We have been operating quite successfully without a staff. I do not know that there is anything else to say.

CHAIRMAN: One question. What is it that made you mourn, Miss Hartry?

MISS HARTRY: It is too long a story.

CHAIRMAN: Tell it please.

MISS HARTRY: In a closed hospital there are four or five men to please, and sometimes it is a little hard to please four or five. In an open hospital there are 45 or 55, as the case may be, and it is a little harder to please the 45 or the 55. At the same time I never quite could understand why any hospital, especially a hospital not operating for profit, not endowed, not receiving any government or city aid, why that hospital should operate for five or six men. Why these five or six men should, at no cost to themselves, ask any hospital to open a workshop for them where they could, as Mr. Olson says, in a morning make anywhere from \$500 to \$1,000, go away, leaving us the patient to care for and the burden of the financial expenses.

CHAIRMAN: Thank you.

DR. NOYES (Columbia): I want to say to the last speaker that she need have no fear of the success of her plan of an open hospital. We have had an open hospital for five years, we have no staff at all, we have absolutely no difficulty in pleasing men, we find it far less difficult to please practitioners in a small general hospital when they come absolutely on the same basis, obligated to no one man more than another, and we have absolutely no difficulty in obtaining free service and attention in the most generous manner from any practitioner from whom we ask it for an indigent patient.

MISS ELIZA SURBRAY (Warren): We opened a small hospital in 1907. There were fifteen doctors in the town of 15,000 inhabitants. The community was very much opposed to the hospital being built at all, said they did not need it. In order to have the doctors all send us their patients we had to put the fifteen doctors on the staff and divide up the staff so that we would have two and three on a month. Fortunately we did not have many charity cases, so that it was not difficult to take care of the charity work. The hospital was built for 25 beds, but we have 35 crowded in, and we get along very nicely with the staff and open hospital. When we have a charity case come in, we call the doctor that is on duty that month, and if it is a surgical case he calls the surgeon, whomever he prefers. We have gotten along very nicely that way, and I might say that our hospital is self-supporting. When we opened in 1907 we had a debt of \$10,000, and we have cleared that off and we are practically self-supporting, no endowment whatever.

DR. FOWLER: I should like to ask some of these gentlemen who have had experience with an open hospital what the effect is on the nurses' training school, if that is carried on. It seems to me that one important thing is, to have some sort of organization and system of regularity, and if there are twenty doctors

coming in with patients, each doctor has a different mode of treatment, a different way of doing things, it might perhaps demoralize the nursing corps.

DR. NOYES: We have a paid corps of instructors for the nurses and the doctor cuts very little figure. A nurse has to nurse for forty or fifty doctors when she is out, I do not see why she should not have forty to fifty doctors to work for while she is in training.

MISS HARTY: In the hospital from where I came I thought there was just one way of washing hands. Dr. George R. Fowler was chief of staff and he washed his hands, scrubbed them and then he put them in permanganate of potash, then he washed them off with oxalic acid, and then he put on his gloves. Now, I left the Brooklyn Hospital with a firm idea that the only way to wash hands was that way. (Laughter.)

MISS LOUNSBURY: I should like to ask Mr. Olson if he advocates an open hospital for ward service or for private room service?

CHAIRMAN: Any other question? Mr. Olson will reply to these at the close of the discussion.

DR. FRANKLIN (Dallas, Texas): I have been listening to these discussions with some interest. We have a hospital now about four years old. The first two years we had an open hospital, entirely open and had no staff, and we had a great deal of trouble. Two years ago we organized a staff and still have an open hospital, and we are getting along better. The question, though, has arisen several times whether or not we should continue the open hospital, or have a closed hospital. One of the points brought up today, seemingly in favor of the closed hospital, is the fact that you do not have so many young doctors there, butchering up people and killing them. I should like to have an expression here this morning as to the death rate in the hospitals, closed and open hospitals. I should like to know, because I do not know whether to continue open or closed. I am inclined to believe with the closed hospital you have a smaller death rate.

MISS JORDAN: I want to make a plea for the young physician. Most all young physicians who are in our hospital have just finished internship in larger hospitals and most of them are pretty capable fellows and I should hate to turn them out.

MISS MINNIE GOODNOW (Boston): I want to answer that last question on the comparative death rate, perhaps it is not fair to answer it on the relative death rate in the open and closed hospital. I have been in two open hospitals and in two closed hospitals. My death rate was much larger in both of the open hospitals, and the results were not nearly so satisfactory. We took anybody and everybody in there practicing and the results were accordingly. In regard to my nurses' training, I think my nurses got better training in the closed hospitals. Very true,



they have to work for all kinds of doctors when they get out, that is no reason why they should learn all kinds of wrong methods, and they do learn them if you have any and every doctor admitted to the staff.

DR. COOK: There was one point made by Dr. Wheeler which I was very glad he made, very glad. We have taken both sides in regard to admitting pay patients and, I cannot state for the cities, but I can state for the towns, and it seems to me we will have this situation: You ask the physicians, if you have a staff, to give their services to the free patients, and there another point suggests itself, that the public and even lay members, trustees—I find that true in our own case—do not realize that no hospital contributes one minute of medical or surgical service. They invite the physicians and surgeons to assist in charitable work by giving their services, and the physicians and surgeons accept that invitation, and it is the physicians and surgeons who are furnishing the work and not the hospitals. That wants to be clearly understood.

Now, to come to the subject upon which I am very glad Dr. Wheeler spoke, in regard to the publicly supported hospital not taking pay patients, where would you be left in any small town? You ask the physicians to contribute their services to care for charity patients and yet you say to them you shall not bring pay patients to this hospital, that is the situation as I understand it when you make that rule, and that does not seem to me to be fair in smaller places. When you ask physicians to contribute their services for charitable work, it seems to me that they should be allowed to bring their pay patients there.

In regard to open or closed hospital, when we began there were certain members of the board of trustees and we assumed we did not know anything about running hospitals, and our rules tended very strongly toward the open hospital. They were submitted to a large number of hospital superintendents, physicians, nurses and others, and all criticised that point, and so we started our hospital as a closed hospital, because we were advised that that was the best method, because, they said, if you let in everybody—I do not know whether it has worked out in those hospitals, but this was what we were told—that if you admit any surgeons to operate, you admit a slovenly surgeon who introduces sepsis in that hospital, it will not be that surgeon or that patient who will suffer, it will be the hospital that will suffer. We are fortunate in this respect, having made an arrangement by which we selected our staff, and they have selected assistant physicians, and we continue that practice today, and every physician but one in our town is connected with the hospital, either on the staff or as assistant physician, and that assistant position allows him to bring in his pay patients. In due time he will be promoted to be one of the staff.

DR. NOYES: I am a doctor myself, and therefore can speak freely on the subject, but I want to challenge one of the statements made. Every doctor who renders free service to the hospital does so for value received. Appointments on hospitals.

are sought, could be sold at a bonus if that were the practice. There is no credit to any doctor that he gives free service, and he is not generous, I think, in doing so.

No doubt the mortality spoken of occurred, but it is not fair to compare the mortality in an open hospital in a small town with that of a closed hospital in a large city and it ought not to be allowed to go unchallenged, the statement made here that the death rate is larger in open hospitals in small hospitals, than it is in large hospitals, and I for one feel that the figures and facts in connection with that statement ought to be produced here.

CHAIRMAN: I did not gather from Miss Goodnow's remarks that she was comparing two small open hospitals with two large closed hospitals.

MISS GOODNOW: I did not hear what was said.

CHAIRMAN: The last speaker said that it was not fair to compare the mortality of open small hospitals with the mortality of large closed hospitals, and I was just remarking that I did not think you said that.

MISS GOODNOW: I said that I had been in two open and two closed hospitals.

CHAIRMAN: In regard to the size, how were they?

MISS GOODNOW: Of the two open hospitals one was thirty and one fifty beds, and of the closed ones, one had 100 beds and the other one thirty beds.

MR. A. O. FONKALSRUD (Brooklyn): I enjoyed the paper exceedingly, particularly as it pronounced my views on the subject. I have had the opportunity to have been connected with two hospitals, one in the Middle West, close to where Mr. Olson is, and one in Brooklyn. The one in the Middle West was a hospital of about 65 beds, in a small town of about 15,000 people, and was an open hospital, and in that connection I will say that if it is a question of putting a hospital on a paying basis, it has got by all means to be an open hospital. It is absolutely futile trying to make a hospital self-supporting and close it, I mean confining it to a small number of staff doctors. The hospital I was connected with out there, as I said, was an open hospital and we never had any trouble from the doctors that came there to take care of our charity patients. At the end of the year we had anywhere from \$6,000 to \$8,000 in our treasury. We did not have any Ladies' Auxiliary or Ladies' Aid Societies of any kind. Our ward fee was \$10 a week. The highest priced private room was \$25, and, as I said, the result was anywhere from \$6,000 to \$8,000 in excess, a balance at the end of the year, all the results of the patients' fees. No patient was refused because he could not pay, all were accepted. The death rate there was about one-third of one per cent. Later I went to a hospital that is a closed hospital. But understand that the one is in a comparatively small city, the first one I mentioned,

of about 15,000 people, the other is in Brooklyn, and the conditions under which the two hospitals are working are, of course, absolutely different in every way. At the closed hospital we have had since I came, anywhere from \$3,000 to \$5,000 a year above our expenses, but remember that in order to have that we have a Ladies' Auxiliary that brings us about \$5,000 a year. We have an endowment fund of \$135,000 that brings us 5% interest. We have special donations and contributions that amount to about \$3,000, and the city of New York pays about \$10,000 to \$11,000 to the institution for so-called city patients, so you understand that by combining all these together we have a little balance, in a sense. Our death rate in the last-mentioned hospital is about 9%, there is the difference. So that is my experience.

I want to say regarding the management of hospitals, in order to have them paying, or self-supporting, I will say again that they must be open, of that I am certain. We have in Brooklyn any number of private sanatoriums, the cause of a great number of private sanatoriums being that the hospitals are practically all closed. Naturally, probably 75% of the good medical men of the city are excluded from hospital facilities. If they take their patients to one of the general hospitals, they claim that their patients are stolen from them, and I presume that in many cases that is correct. I, for one, cannot blame a doctor for not being willing to submit to anything like that. They will go and erect private sanatoriums, and, mind you, a private sanatorium is, as a rule, well managed, self-supporting, it pays; it is good business. I will say this, that there is a great difference between the management of a hospital out in the Middle West and out here in the East. Out there any one with fair business ability can easily manage a hospital and manage it without any deficit, but manage it and even make money out of it. Out there, from my experience, hospitals can be run as a good business proposition. Here in the East I fail to see that that can so easily be done. Rates and conditions are so entirely different, and I feel that that is really one thing that should have entered probably a little bit more into our discussion this morning, that we distinguish between what is needed for various sections of the country. The hospital question, as I learned to understand it, is something like the tariff questions. Certain parts of the country want low tariff on certain articles, others again want high tariff, it all depends on where the shoe is going to pinch you. That to a certain extent is true of hospital conditions. What is good and proper in one section is bad in another section. Out West we look upon the hospital as more of a business institution. In the East I am becoming convinced that it is considered more strictly a charity institution and that it is contrary to the spirit of hospitals to make it in any way mercenary. Which is right, I shall not enter into discussion.

MR. HENRY E. W. SIMON (Buffalo): Being a western man, I, of course, have enjoyed the address of Mr. Olson very much, because Minnesota is my native state; I was born there and came to the East. When our good brother from Brooklyn came up and made the statement that closed hospitals could not



be made self-supporting, I wanted to challenge the statement, because I am superintendent of a hospital which is closed and which up to last year has been able to pay all its bills. We erected a new building and on the 8th of October moved into it. We have a debt of about \$185,000 on that building and that means a very large interest payment. We have in our hospital 59 ward beds. Our charge for wards is \$1.25 a day. We have 50 private rooms for which we receive from \$2.25 a day to \$5.50 a day. Our interest payments are large and they have increased from \$900 up to over \$9,000 a year. In addition to that we have connected with our institution an Old Folks' Home. That is probably something unusual for a hospital to have an Old Folks' Home connected with it. We have 54 old people in that Old Folks' Home. That causes a deficiency in our \$5,000 a year. We were able to close this fiscal year with a deficiency of less than \$4,000. So I think that refutes the statement that closed hospitals do not carry their own expenses. There is one danger, however, in a closed hospital which I have observed and which has caused me considerable concern and a great deal of difficulty and that is this, that if you have a prominent surgeon on your staff who is known to be good and everybody knows that he knows his business, can do good work, there is this danger, that he is going to use his influence in every possible way to have men appointed to the staff who are going to feed him and that is a danger that must be very carefully avoided. It means a great deal to a hospital to have a sort of Czar-like rule from the staff. It means that you are going to get the support from the public that you should have when you have deficiencies, and I think there is where closed hospitals need to be very careful. I think when you want to raise money the thing that needs to be done is to give due publicity to the work that the institution is doing, and then have behind you a good organization which is going to support you in the work that you will undertake. Our institution last spring raised \$116,000 in two weeks without very much effort and it was all done without a great deal of publicity. I want to refute the statement that closed hospitals cannot be made self-supporting.

CHAIRMAN: There is another paper before luncheon; I think we shall have to close. I will call on Mr. Olson to close the discussion.

MR. OLSON: I put down a few points on which I want to refute the speakers, or corroborate what they have said, affirm it or give a little further enlightenment.

A lady here asked how we do with regard to enforcing the open, or practicing the open hospital rule in the wards. Our wards are just as open as our private rooms. Because a patient is admitted to a ward is not necessarily an indication that he is poor. We will have patients, farmers who probably own \$50,000 in property, can write a check for \$10,000, who insist on getting a ward bed, because it is better than they are used to at home. There is no reason why we should not permit the doctors that we admit to the hospital at all to practice just as freely in the wards as in the private rooms. Nobody knows which of our

ward beds are free and which are paid. If we have an applicant for the bed in the hospital who cannot afford, who has not the means for his care, he is admitted just the same as any patient who walks up and pays the customary two dollars, and nobody knows whether he is a charity patient. I think it is a mistake to set aside a certain number of beds and say, "These are free beds." It has a bad influence on the nurses and physicians and others. We do not label our charity patients. If they require a private room and a hospital nurse, they will get them. Our means of paying for those patients are the means that the Good Samaritan found. We find recoupment through our Association, our Ladies' Auxiliary or our private benefactors, who probably never want to be known, or request of us to conceal their identity—they pay the expenses and nobody knows which is the charity patient outside of myself and my confidential clerk. We are very careful, however, that the physician who treats that patient does not get any money. If we find any of them doing it he is forever put out of our hospital. There must be co-operation in this work between the hospitals and the doctors. The hospital does not make any money on those cases, does not try to, but we want to get out of it, if possible, what it costs to maintain that case, and, as one gentleman said here, the doctors are vying with one another in soliciting or asking for those cases. I have men walk into my office and say, "I have not had a charity case for a long time, you are forgetting me, what is the reason, haven't you got confidence in me?" They are perfectly willing to treat these patients free.

Our hospital is as open as I believe any hospital to be. It is closed only in this respect, that we exercise some discretion as to the admission of physicians. We do not admit any Tom-Dick or Harry, who comes along with an M.D. after his name. I have a local medical roster at my receiving desk and we do not admit any man to practice in our hospital who is not a member in good standing of the local society affiliated with the A.M.A. If he is a recent arrival and is not yet transferred, we are careful to find out that he is an A.M.A. physician just the same. I do not believe in a medical trust, but I believe in some safeguards.

Now as to the death rate in open hospitals as compared with the closed, I do not know of any difference, that is, I have not studied statistics. We have had a death rate in our hospital of  $3\frac{1}{2}\%$ , that is, 35 patients per 1,000 admitted. I do not know whether that is high or not,  $3\frac{1}{2}$  out of every 100 that were admitted died in our hospital. Ours has been largely a surgical hospital, doing a great amount of country work, referred to us by doctors in small towns. In a majority of these cases the people do not come to town unless they are pretty nearly hopeless, so that I think a death rate of 35 out of a thousand is not so very high. Out of 3,024 cases, over 2,700 went through the operating rooms, so I think that with a death rate of only  $3\frac{1}{2}$  per 100 we are fairly safe. We have a staff at present of 38. Some are medical, some are surgical, some obstetrical, some eye, ear, nose and throat, and they are assigned each a certain

period of weeks or months, everybody being treated alike as much as possible. They are called to take care of cases there that are coming to the hospital without having a physician selected beforehand. There are not very many of these cases, but there are people who walk in and say, "I am sick, I want to be taken care of, you have doctors here to take care of me." Well, if that is considered to be a medical case after examination by the chief of the house staff, we call the man who is on duty at that time on medical service; if a surgical case, the man on surgical service is called. If that proves to be a charity case, or very poor, he is not allowed to charge, but in some cases it proves to be a miner or lumberman, or somebody from out of the woods, who comes up and has a roll of a thousand dollars or so in his pocket, we do not begrudge the doctor the little fee he might ask for the attention he gives the patient.

As to the point I made in my paper in regard to hospitals supported by taxation: not taking pay patients, I referred to hospitals that are built by bond issues and supported entirely by taxation in order to perform the compulsory charity work which the community feels it is bound to do. In our city we have a city hospital that is bonded to the extent of a million dollars to build that hospital and we are taxing ourselves a great amount each year to support it. I object to such hospitals coming in, taking private ward obstetrical cases in the eleemosynary rooms at less than cost, so that we have to pay taxes to maintain those patients. We have, I might say, as a means of taking care of a good deal of work a system of looking into cases and finding out where the responsibility is for the patient. We have sometimes poor patients sent in to our hospital because it is known in the West, sent in from North Dakota and other places out West, they simply put them on the train and tell them, "Go to the Swedish Hospital." They come to us, they may have given them the necessary two weeks' deposit to pay down on coming in, but when that period is over we cannot put them out unless they are well. I investigate very carefully and when I find such a condition I go to the county authorities and invariably I get an appropriation from the Poor Fund for the further care of such patient. I just collected a bill the other day of \$250 in such a case.

Now the thing to do to make the hospital self-supporting—and we have somewhat digressed in our discussion, from the main question—is to watch every source of revenue. Keep your fingers on it continually and do not let anything escape, because it is no justice to a person who beats you and it is a gross injustice to the people who are helping to support your institution. We have opened a new line of discussion and it is hard for us to keep out of the straight and narrow path. You know we have discussed how to cheapen the food and how to economize in this and that, why not begin to discuss how to increase our revenue, how to get what it is worth? I have not always been a hospital man, it is less than two years since I took part in another business which ten to fifteen years ago was in the same condition. They were simply vying with each other to cheapen the work and put a cheap product on the market. One man after another was quitting the business



and going back to the farm or raising chickens. Now that business is on a paying basis and they are paying dividends, because they began to study their costs, they began to find out where they were not getting any thanks or anything of the sort for distributing their product for less than cost. Nobody is going to thank you for doing that. Why not charge what it is worth? The doctors have solved this question long ago. Where the patient cannot afford to pay a decent fee they do it free. Otherwise they keep up their regular fees and they have made them high enough, they have based them on the circumstances of the patients, because they keep up their fees to a certain point. That is what the hospitals ought to do. If you find that your patient cannot pay nine dollars a week for his care, charge those that can pay full price and make that price large enough to give your institution a just and good living and leave something to surplus which you do not have to disburse to stockholders, but which you can disburse to poor patients who cannot afford to pay the price.

CHAIRMAN: The next paper is on "Ambulance Service for Small Hospitals," by Miss Margaret Moore. Miss Moore is not present. What is your wish? It is now ten minutes of twelve; I am sure that there are many points in this paper of Mr. Olson's that we have not thrashed out, and possibly some of you may be disposed to wait fifteen to twenty minutes and take up other points. Those who are in favor of talking on a little longer in a free and easy way on any side topics that may have arisen, or on the main question, will please say Aye. We will continue in session a little longer.

MISS JORDAN: This question arises occasionally, of a patient becoming dissatisfied with his doctor, and the doctor claims he has the right after bringing a case to a hospital to take care of him. Is it well to change doctors in a hospital? I know that it is the judgment of the superintendent many times that it would be better to do it, but whether or not we should be allowed to change physicians in a hospital ward is a question that I should like to have answered.

MISS SURBRAY: We leave that entirely with the patient's friends and let them decide. If he has not any friends, then we let the doctor that is taking care of him and the doctor that he prefers thrash it out between themselves.

CHAIRMAN: I should like to ask Mr. Olson if he gives an intimation to the patients or to the patients' friends of these extra charges, what we call extra charges, when they are admitted to the hospital.

MR. OLSON: We do, we explain that very fully, that the rate is so much for the room or bed, and then we say there is an additional charge for the operating room services and the supplies used there and then; they are to pay for dressings and medicines all that is required, and that is all left to the doctor, whatever may be required. The patient has to take a chance on that, we do not take any chances on it. As I say in my

paper, it is unfair to adopt a round figure as to rates of payment. We go into it exactly as you go to the hotel; you live on the European plan with everything else a la carte.

DR. FOWLER: The death rate is a very uncertain factor. In our hospital the death rate is 7.3%. That may seem large. The death rate in surgical cases was a little less than 7.3%, if I remember the figures, notwithstanding the fact that the New York Central Railroad is carrying on large work, such as widening the track, etc., in our vicinity, and there are very many serious accidents brought to the hospital, our hospital being practically the only hospital within a radius of some twenty miles. Likewise the same work has been carried on by the Central New England Railroad, so that we have had a great many serious surgical cases. Notwithstanding that the death rate is something, I think, less than 7.3%, but the death rate in medical cases was something over 10%, I do not know but 11%, due to the fact that many of our deaths were old people over sixty years of age who were sent there to die, patients who were in a hopeless condition. I think the greatest death rate was in cases of pneumonia and, if I recollect rightly, among Italians who were employed on railroads, so that you never can say from the death rate necessarily whether you are doing good work or not.

CHAIRMAN: I should like to find out from the members present—I should judge there are about 150 of you here—to find out how many of you are in charge of closed hospitals. Would you mind voting, those of you who are in charge of closed hospitals will you kindly rise, then the rest will see and we will get some idea. Those representing closed hospitals are standing now, about 24. Be seated. I presume the rest are in charge of open hospitals, but in case there may be visitors not in charge of hospitals, those in charge of open hospitals please rise. Well I should say there are twice as many, roughly speaking. The two points in respect to open hospitals—the two criticisms are with reference to the nurses learning improper technique, and the poor surgery. Every once in a while I am hearing of tragedies occurring in open hospitals from incompetent men. I should like to hear a word or two from those who have open hospitals—if you feel like telling your experiences—if you have any experiences of that sort, what means you take to obviate recurrences of that sort of thing, because it means inefficiency and it hurts the reputation of the hospital.

If there is any one here from Iowa, where they have hospitals partly supported by the state, if you would give us experiences from the hospitals in Iowa it would be interesting and bear on Mr. Olson's paper.

DR. N. F. MOSSELL (Philadelphia): I voted with those that stated that they had closed hospitals. I did that because the hospital I represent with 75 beds is practically closed, and yet our law says that any physician may bring a patient there and treat the patient while there, except in operative cases, and in that case the hospital reserves the right to designate who shall

operate. That is, no man is allowed to operate unless he has a reputation as a surgeon. Notwithstanding that is printed in our rules, we have very few men come there to attend their own patients. I presume that is due to the fact that most hospitals in Philadelphia are closed hospitals and they do not think of coming.

Another thing, we have a physician who is superintendent of the hospital and they feel that we would have to follow the rules laid down by the board of directors and operate through the medical director. Now in that respect we do not find that we have to have restrictions as to operations, we find no trouble. We have few men, if any, asking to operate who are not competent. I have listened to the discussion carefully and I really believe that there will never be a unanimity of opinion on this matter, simply from the fact that some hospitals feel that they must run in order that they may get all the financial support possible and others feel that they cannot run unless they are run on a strictly scientific basis. Until the medical profession is elevated, it is impossible to have an open hospital and run it on scientific lines, because there are really a large number of physicians—it does not make any difference whether members of the A.M.A. or not—a number of them are not competent to do thorough service as it ought to be done in a hospital. In other words, a doctor who has been practicing five to ten years in a private family, will do service in a hospital that will even disgust the nurses, and we find that we cannot stand for it.

MISS NORAH D. ABBEY (Ashland, Ohio): In two hospitals with which I have been connected the trustees see fit to support the hospital staff by not allowing major surgery performed without the consultation of three of the staff and the superintendent.

MR. PALMER: I want to ask for information if this Association has ever passed any vote by which there is any dividing line between the so-called large hospitals and small hospitals. Is a hospital of 50 beds a small hospital or a large hospital; is a hospital of 75 beds a large hospital or a small hospital?

CHAIRMAN: I do not know that this Association, except in the report that was published three or four years ago, in respect to nurse-training—I have not the report by me and I have forgotten about the condition that was made—apart from that there has been no action taken by the Association, so far as I am aware, of deciding just where the dividing line is between large and small hospitals.

DR. NOYES: I think that is a state of mind. All those who have problems to solve are small hospitals and all those who have their problems settled belong to the large hospitals. (Laughter.)

MISS SARAH HAYDEN (Augusta General Hospital, Augusta, Maine): We have a rule which states that all patients who by the open method are entered in our hospital shall be put in private rooms and that all such patients are made to understand that the hospital is not responsible for any errors or blunders



or any fault whatever in the care of the patient. That is one point I thought perhaps might be of interest. We have about half a dozen men during the year who avail themselves of that practice and it is gradually lessening.

DR. FRANKLIN: I should like to ask Mr. Olson and others with regard to payment when patients come into the hospital, as to whether payments are required in advance or not.

MR. OLSON: We have a rule posted prominently at the receiving desk and at the cashier's office that we require two weeks' deposit in advance at the rate of the accommodation which the patient engages and then the notice says further that patients not able to comply with this rule must make arrangements with the superintendent before admission to the hospital. Under that rule I get an application from people who say, well, I cannot pay for more than one week, or, I have not any money with me, but I have some in the bank. Those are referred to me and I can find out what the conditions are. Very often these people came in without more money than to pay railroad fare and carriage to the hospital and they have plenty of resources back of them and they have got to get right into their beds. I get a draft, or whatever is necessary from them, sometimes sell their farm, if necessary, or mortgage it. There are some people, young men particularly, who come in from the lumber camps or the farms after the farm work is closed, who have contracted typhoid. They take lodging in town, are taken sick and enter our hospital. Usually they have enough money saved up to pay for two weeks in advance and they have to stay six or eight or ten weeks before they walk out. Then they are not able to pay what they owe. Those we have to take care of in another way. If we find they have no friends who can help them out and they do not belong to any societies and are absolutely left without resources, we take their promise as men of honor. Recently I collected a debt of that kind four years old from a young man who had come in from a lumber camp and left with a bill of \$90. We do not take notes, because notes are worthless, simply take his word of honor, that is all, that he will pay. We are always careful to get all the references we can through relatives; even if they are in Europe, we get the names and addresses of relatives. I located this man as foreman of a large paper mill in northern Minnesota, and I wrote him, reminding him of the debt, and he wrote back, "Why, sure, here is your money with interest. I forgot it." It is no charity to let those fellows get that treatment for nothing and the city hospitals who take those fellows without any obligation to pay it back are not doing any real good to them. They think, "I can use all the money for drink and other things; I do not need to pay for any hospitals; we do not need to pay for anything in this country." We have had difficulty with professional people, lawyers and others, who send their wives and daughters to the hospital, they must have the best of everything and run up big bills. As to asking them to pay for two weeks in advance, it is out of the question, because they are so well known. They may run up bills for

\$200 or so, and they say, "Send the bill, I will send you a check by the 10th." Usually that 10th never comes around, that particular 10th. Of course we have to use diplomacy and usually get the money. I have never sued for a hospital bill. I have threatened suit, if that did not work I laid down. I do not want to get the publicity of having a case in court, have it said that I had a suit for a hospital bill, not because it hurts them, but because it hurts us.

MISS FEATHERSTONE (Havre de Grace, Md.): I am very glad that the question of collecting came up, for I have charge of a very small hospital, smaller than any I have heard mentioned here. I have 16 beds and this is the second year of our existence. Our first year we had 105 patients, 85 of which were surgical and the remainder medical cases. We had a death rate of 13, sever moribund when they were received. At the end of the year I found I had a deficiency in my collections of \$305. It is small, but my hospital is small and we have not been able to collect it. Two of my debts were by merchants of the town who wished the best that the hospital could afford them. I have sent out a bill to each regularly every month and have never had any more notice taken of it than if it had not been sent. We have but five doctors in the town and each one gives his service for one month to the free patients. All the others who are pay patients have the choice of selecting their own physician. I have but three private rooms and four wards, three beds in each ward. The ward beds are not labelled free or pay. They are charged either five dollars a week or a dollar a day for beds that are not free. We have an appropriation from the state of \$5,000 a year for two years. The Maryland Legislature only meets every two years and an appropriation is made for that term. We had \$1,000 from the county last year and this year we received nothing. The hospital has been opened against considerable opposition. The doctors have not gotten quite into regulation as to entering patients. I have patients entered very often as pay patients and am utterly unable to collect. They say that they do that because their own doctor wishes to treat them. That is hardly fair to the hospital, and one of the questions I was in hopes of hearing discussed this morning was how to meet such an imposition. The subject of the expenses of a hospital I have not heard at all. There was another subject that I was very much interested in, and that was the surgical supplies and the food. Our little town donated rather large sums to the hospital, and in that way we purchased the ground and the building on it with a mortgage of \$10,000 on it. We have only been able to clear away a \$500 note this past year, but we are in hopes that we will do better as we go on. We are buying everything in rotation from each dealer in town, which is an exceedingly disagreeable way for the superintendent to purchase. Each dealer has his own price and there seems to be no uniformity, that is, some man charges more and says he has to pay more, and another charges less. I found that they were charging us the retail prices that they were charging any small consumer. I finally had that arranged so that we could have

hotel rates. I am in Havre de Grace, Maryland, and that has but a small number of inhabitants, and one of the questions was, as I say, this matter of food purchasing that I wanted to hear, and another question was as to how collections could be made for small hospitals.

MR. A. O. FONKALSRUD (Brooklyn): I want to say by way of comparison that in the Middle West, where I had some experience for the first time, all patients enter with the understanding that they are to pay or make provisions for payment. In the East our experience is entirely different. We have insulted any number of patients in Brooklyn; they were indignant that we should even ask them to pay, and as to the enforcement of outstanding bills, if we consider bills of that kind, I do not think we could do much in the way of forcing them. My experience out there was this, as has been noted by Mr. Olson, that we send bills to counties in the state, or outside of the state, and they would invariably be honored, they would pay for Wisconsin, Minnesota, Iowa or any place where they should be honored. Supposing we should commence to practice the same thing in Brooklyn where we have so many foreigners—I have seen the statement made that New York has only 6% Americans and the rest of them are foreigners. I think in some quarters it may be as bad as that, but at any rate there is a large number of foreigners. If we were to pursue a course like that it would mean that we would have to go to European countries, for probably 60% of our patients are foreigners. What are we going to do? We are forced to take a different procedure than would have to be done in other places, so that what has to be done in one place cannot be done in others, so that we have to meet the emergencies as they arise in different places.

CHAIRMAN: We have a meeting this afternoon and one this evening. I think it is well that we should bring this session to a close. We will assemble again in this room at half past two.

Recess until 2.30 p.m.

### WEDNESDAY, AUGUST 27—AFTERNOON SESSION.

SECRETARY BROWN: If Miss Morrison is not present, will the members elect a chairman, or shall we go ahead as we did this morning?

A MEMBER: Go right ahead as we did this morning.

CHAIRMAN: We will proceed as we did this morning, with the small hospitals' section.



**WEDNESDAY, AUGUST 27—AFTERNOON  
SESSION.**

**WHAT THE AMERICAN HOSPITAL ASSOCIATION  
CAN DO FOR THE HOSPITALS  
OF AMERICA.**

**BY E. P. HAWORTH,**

Specialization, concentration, standardization and co-operation are the key words to modern progress. Oppose it though we may, power in all lines of human endeavor is being concentrated. This calls for specialized knowledge and ability in every field of work. The more thoroughly our efforts as workmen are specialized, the higher the standard of all labor and the products of labor. And around it all and through it, binding all mankind and the products of his efforts together, is growing that brotherly love, that altruism, that spirit of co-operation.

As it is in the world at large, so it is in the hospital world in particular. Larger and larger hospital corporations and their plants are being developed. They are specializing men to a point of capability of doing miracles through the aid of their wonderful hospital buildings, apparatus and instruments. It is becoming more and more the effort of the hospital world to bring its poorest and most inefficient member up to the standard of its best qualified—this through the co-operative efforts of the most capable members and their organizations.

Of all the professions probably none is more co-operative than that of the physician whose very basic principles, medical ethics, are founded on altruism and brotherly love. And so the hospital, the home of his work, is grounded on the principles of helpfulness and humanitarianism. This devolves upon the American Hospital Association, the organization over all the hospitals of America, some heavy duties to its constituency

and some wonderful fields of opportunity lie before it all unentered. Such an opportunity as now exists in the hospital field, for organization work and aggressive educational development, has long been met and seized in almost every other line of work in this country. Hospital organization alone is being neglected in its broad possibilities and many of its needs.

A vital question is whether the Association is now far enough advanced that it can make some vital changes that will mean progress and aggressive work. Is it big enough and powerful enough to do some things that need to be done but have never been attempted? Has it organization enough and money enough back of it, to launch out into new work that will eventually mean the saving of hundreds of patients' lives in the hospitals of America every year? Or if it lacks the money, has it through various of its members sufficient ingenuity to obtain the required funds to meet its present needs?

It is not the purpose of this paper to say what the Association should do. Far be it from even suggesting what it should do. It is only purposed to bring out various ideas that might be followed if, after due consideration, they were found practical. Some of these ideas are vague and general and would require considerable space to elaborate on them properly. Others are concrete and specific in their details.

These suggestions have been gathered from various members of the Association and from the hospital publications. The writer has found it necessary to elaborate upon the ideas of others in some cases, but credit for the ideas is due others with few exceptions. If this paper should be the means of inspiring some changes for the benefit of the hospitals of America, the authors of the respective suggestions would be pleased and the writer would feel well repaid for his humble service in the matter.

Now, fellow hospital workers, let us consider the plan of our organization's work and see whether a material change could not be made to advantage. We have a conference once a year. This is about the sum total of the Association to most of us. True we have a President and other executive officers who hold office throughout the year. Various committees are appoint-

ed and some have meetings during the year and perform vital duties. But to most of us the American Hospital Association is a four days' conference once a year. There is no permanent headquarters, no permanent organization, only the meeting. We have no man permanently employed to whom we can write about our difficulties, no place to get expert advice, no man so salaried that he can devote his time to the problems and tasks this Conference could give him, to occupy his ensuing year's time.

Let me ask if this is not too serious a handicap to organized aggressive work, to permit the condition to exist another year. We have an excellent secretary who has done all he could be expected to do under existing conditions. But do you not think he could make a valuable change in the work of our hospitals if he was salaried to devote all his time to the work? He has some excellent ideas of things that should be done by and for the Association, but he has neither opportunity nor authority for doing them. A good salaried secretary working under orders from this Conference and directed by a live executive committee clothed with proper authority to act, could easily earn his salary raising it from sources not now considered as resources.

Let us consider some of the means whereby sufficient funds could be raised for supporting a permanent headquarters and a secretary. I believe this matter was up before a special committee recently and they decided it was inadvisable at the time. As to the details of the ways and means canvassed, I am not familiar. Or whether they considered any new means for obtaining funds other than the present source of the Association's support, I did not learn. So we will study a few methods without reference to any former consideration they may or may not have received.

Through the present channels of funds two courses might be pursued. An increase in membership fee might be charged. This course, I doubt if any would favor as the fee is at the present about the limit found practicable in national organizations of a similar scope of work. On the other hand a lowering of the fee would probably not increase the membership in sufficient proportion to augment the income materially



without other possible changes being made in some direction. Let us keep the membership fees as they are but increase the possible members in two ways.

Why not include other hospital executives than superintendents of hospitals and hospital trustees? Include superintendents of nurses and other department heads. We will find that their ideas will often be well worth listening to and why not avail ourselves of their aid? If a point that will be brought out later in this paper, the Hospital Executive's Institute, should be decided upon, it will make it possible and practical for many of these lesser officials to be in attendance. And, besides, our superintendents are largely developed from these under offices and let us get them into training as soon as possible.

Again let us utilize every means to make our Conference and the work of the Association as valuable as possible to hospital people. Make it such that the smaller as well as the larger institutions will wish to become members and attend the Association's meetings. Let us interest the hospitals in the West, the South, the Southwest and the Northwest as well as just here in the eastern part of the United States and Canada. All these other sections of the country need help—even more than here in the East. If conditions could be thoroughly studied, some facts would be learned that, I am sure, would be appalling to you people who know what hospitals are for and how they should be run. Show more of the representatives of hospitals that the Association stands for something for them and we will get their support.

A way for increasing resources outside of channels now employed, would be for the Association to have its own hospital publication, following the lead of the American Medical Association. This looks both practical and desirable. Following the close of the last Conference, the writer took occasion in a report on last year's Conference published by the hospital he is connected with, to suggest the advisability of an official organ of its own for the Association. Since that time the International Hospital Record has discontinued its official capacity in connection with the Association. Also a new hospital journal has been planned and is

ready to offer us its first issue in a few days. Just what its plans and hopes are with reference to this organization, I do not know. But with a good editor and a good staff of contributors as would be available, I feel safe in predicting that an official monthly organ, owned and run by the Association, modeled after the plan followed by the American Medical Association and perhaps a score of State Medical Journals, would be a good source of income as well as paying its way. This would assure us as individuals the opportunity of getting in touch once a month with the Association and the constructive aggressive work it could and would be doing throughout the year. It would be a source of inspiration to us and we could keep tab on whether the Association was doing anything. It is practically impossible to get anywhere from one year's end to the next with no present means of official inter-communication. With the monthly journal as an aid, official announcements and inquiries may be made, and official and individual discussions and educational plans may be carried on with alacrity and results. Only a slightly detailed outline of the plan and value of an Association journal would require more time and space than may be devoted to this entire paper. But to one who is familiar with publication work the considerable income available from its advertising space from the start, is self-evident even though no subscription price should be charged the Association membership.

Incidentally the Association journal would aid in educating the hospital public to the importance of attending the annual Conference. Also special educational subjects might be systematized and studied through its columns. The hospital field has many big, broad-gauge people who will respond with time and effort to the needs of the American hospitals, if these needs can be brought forcibly to their attention by some one whose business and authority it is to look after such matters.

Then there is the plan of endowing a secretaryship. As much wealth as there is looking for an outlet in some good charitable purpose and with many of our members in touch with the sources of such wealth, this course is possible and perhaps practicable. Surely

some of our members are in touch with money that is not available for use in their own undertakings, that they could and would interest in as fruitful a purpose as this.

There are two handicaps to endowed offices. When ample support is assured without effort in a financial line, we are apt to become slack in our work. We usually are most successful in those businesses in which we have to strive the hardest. If we might hazard a suggestion we would say that perhaps the tardiness in general hospital organization is due to much extent, to the fact that most of our heaviest hospital people are connected with hospitals that have municipal and charity support all or in part, and are not burdened with financial handicaps or the desire to make money as in commercial work.

Again an endowment is too prone to be provided, hampered with provisions. People of wealth are inclined to think they know or to be under the influence of others who think they know, just how their money can be spent to the best advantage. Often their views are prejudiced. And the course of a few years may see conditions so changed that what was originally advisable, would no longer be for the best. So I say that if an endowed secretaryship may be provided without any jurisdiction other than this Association provides, it might be a satisfactory plan. But if a financial competence independent of effort, means stagnation of efforts in a few years, naught has been gained. And we had as well not waste our time in planning.

A thing to be hoped for shortly if not at present, would be an expert subscription superintendent. It would be his duty to respond to the call of needy hospitals. Were they about to go bankrupt for lack of proper support he should go to their aid. He would be an adept in methods and plans. If they wished to run a big subscription campaign for a new building or an endowment, following plans employed in the Y.M.C.A. and other fields, he would come and organize the team work for the canvassers. If hospitals were operated as private business and commercial institutions, this secretaryship could be made a source of some revenue for the Association. In other words, the service of this



expert would be charged for at a rate to produce a profit above his salary. His services would be an excellent investment for a hospital and for this organization at the same time. Just how quickly this could be started to advantage is questionable, but a man is needed now.

Doubtless the move of most importance for the Association is to provide a permanent secretaryship and headquarters. Only second in importance to that, probably is the organization of subsidiary sectional or state organizations. These will reach out over the country and interest many hospital executives not now acquainted with the Association. Probably most states would be too small for an organization of their own, and would need no concerted effort except in case and on matters of state legislation. But a half dozen to a dozen associations could well be organized to cover the United States and Canada. This many would provide sufficient members to make the work interesting in each Association. Also they should be so classified as to make each group one in climatic and other problems that affect their hospitals.

It is best that this organization work should emanate from the American Hospital Association so the outline of states in each group could be controlled. This is important for three reasons. First, the larger organizations could see the whole field with its larger vision, decide better what states should be included in each section. Second, it could see that no state was left out of all organizations. Again under the direction of this body some person or persons could be delegated to start the organization in each section and such persons would go out with the stamp of approval and authority for their work. They would not feel that they were forward or overstepping the bounds of propriety.

If this Association and its Conference are worth while, the smaller ones with their comprehensive study of local conditions not within the reach of this body, are worth while. Anything that will aid in the elevation of the standard of hospital work in the hundreds of little hospitals being built in the rural districts especially, will be a great boon to humanity. The medical fraternity is now trying to reduce the number of physicians annually admitted to practice in hospitals and in the

private family, as well as raise their standard of efficiency. In like manner we should raise the efficiency of the hospitals in which these doctors are to practice.

Another matter of much moment that is within the province of this organization, is the holding of an institute, assembly or chautauqua, as you wish to call it (for convenience we will call it an institute, though the name may not be the most apt) annually, for the aid of hospital executives and potential hospital executives. This might be for a period of ten days or two weeks and held just prior to this Conference. It would probably be preferable for it to be held at one of the chautauqua or other lakes in Indiana, Michigan or Wisconsin. This would make it centrally located east and west and in an attractive place and latitude for a summer outing. If study can be made to combine with pleasure in the form of an outing the Institute will have gained a double end and doubtless double its attendance and attractiveness. The slack hospital season, some time during the summer, should be used.

Some have suggested that the institute should be held each year in the same city in which the Conference is held and just preceding it. While it would have some advantage in the attendance of this Conference, it might lose more in its own usefulness. At such times as this Association met in some extreme part of the country as for instance this year, it would be less convenient to the larger body and would doubtless lose in attendance accordingly. True it would have the hospitals for clinical demonstrations but it would also have the handicap of counter-attractions to distract one's thought and interfere with regular attendance upon lectures and addresses. It would seem that the best time for holding the Institute would be immediately before this Conference, with time given to reach this Conference after the last session of the Institute is over.

At the present time there are some larger hospitals offering to train hospital's executives. But the number they can accommodate is very limited. On the other hand, we have those executives now working in hospitals and who have no time to get a hospital training for they have already entered their field of work. And yet they recognize the need of keeping up-to-date and could spare a little time to combine education and

pleasure. They would take the time to attend the Institute. To these executives might well be added any nurse or physician or other member of a hospital organization, who might wish to attend.

As lecturers and speakers of the Institute, some of the strongest hospital specialists in every line could be provided. These men and women are widely scattered, seldom more than one in a single hospital staff. But they could spare a few days once a year to deliver their lectures to the largest body of hospital students in the world. All lines of work in hospital operation and management could be considered and a comparison of results from different sections of the country and under varying conditions discussed. With such an opportunity for study as this would afford, the ablest men of the hospital world would gladly proffer their assistance.

So much for changes that might necessitate vital alterations in the plans of the Association.

Now let us consider some matters that may be taken up whether any, all or none of the former suggestions are now considered practical. For instance, the following points brought to our attention by G. W. Olson, Superintendent of the Swedish Hospital, Minneapolis, Minnesota, are all pertinent and feasible. He suggests as follows:

"The American Hospital Association should devise a uniform system of cost accounting, variable enough to be adaptable to the needs of the municipal or free hospital, and to the voluntary pay-patient or semi-charitable. It is very essential that every hospital knows the cost of the service it is rendering, whether that service is sold or given away—in either case its cost should be known, and this knowledge must be of the minutest detail to be of any real value. Good cost systems are undoubtedly already in use in many hospitals, which have through patient study and effort worked out the problem for themselves. An effort should be made through a commission appointed for the purpose with an adequate appropriation for expert advice, to work out the simplest and most efficient system possible. The system should be patented by the Association and its introduction and installation promoted and superintended by a paid expert. A price should be charged for the use of the system, graduated according to the



bed capacity of the hospital, and thus a revenue produced to pay the expert and the cost of creating the system. A similar plan has during the past few years been worked out by the United Typothetae of America, the national organization of commercial printers, with wonderful results to its members.

"The American Hospital Association should work for the standardization of staple medical and surgical supplies used by hospitals. An 'A.H.A. Standard' should be established both as to quality and style of package. What has been accomplished in this direction by a local organization in New York City should be duplicated in the national organization for the benefit of all its members. The bewildering variety of gauzes, cottons, cat-guts, rubber gloves, water bottles, tubings, etc., now offered by all sorts of people at all sorts of prices is not designed to conserve the time and energies of the busy hospital superintendent nor is it beneficial to the hospital exchequer. There are altogether too many fakers in this line of business. If deemed practicable, the American Hospital Association might establish a central purchasing bureau through which members might contract for their annual supply of some of the staples named. The National Druggists' Association has done something along this line for its members.

"The American Hospital Association should formulate a code of ethics to be observed by hospitals in their relations to the physician, the professional nurse, the public and one another. Reciprocal relations should be sought with the American Medical Association and the national organization of professional nurses, in order to arrive at the best solution of this question.

"The American Hospital Association should be re-organized so as to consist of hospitals and not of individual persons. Membership fees should be graduated according to bed capacity. Any trustee or officer of a hospital which is a member should be eligible to participation in its meetings. Then the Association should attempt to establish some really valuable service departments and features along the lines suggested above, and many other things, suggestions for which might be obtained through study of plans and methods of other national associations, such as the

Bankers' Association, the Hotel Men's Association and many others.

"Services such as hereinabove suggested would be of greater value to the small hospitals, perhaps, than to the larger ones; but I am convinced that they would prove of some value to all.

These points made by Mr. Olson are of vital interest to the hospital world as are the following made by our friend, John Wells, Supt. of the Latter Day Saints Hospital of Salt Lake City, Utah:

"What I would like to see developed in the Association," says Mr. Wells, "would be a sectional system, by which those superintendents operating in smaller hospitals could have round table talks with those operating hospitals of similar size. I would also like to see a large private hospital section so that part of the day could be set apart for them to meet and discuss the problems that vitally affect a private hospital. There is a great deal of difference between the heavily endowed and municipal hospital, and the institutions that have to earn every penny they spend.

"My visits to the Association conventions in the past have been very profitable. It is very noticeable that the discussions largely evolve and are handled by those who operate municipal hospitals or else others that are heavily endowed and do not have to *scratch* for a living.

"Another thing I would like to see developed, and that is the commercial exhibit and I think it ought to be under the auspices of the Association, and encouraged instead of discouraged. Those who come long distances to attend and do not have easy access to hospital supply centers, look upon the commercial exhibit as a distinct advantage to them, placing before the superintendents new ideas, keeping in touch with those whom they buy from through correspondence."

Probably no member of this Association has spent more money in attendance upon its Conferences since the organization was established, due to the long distance necessary for him to travel and the regularity with which he has attended since joining the Association than Mr. Wells. He comes East to learn more about hospitals, hospital apparatus and how to operate hospitals. Coming from a hospital of about one hun-

dred and twenty beds, he recognizes vital problems in his work, not met in many of the larger institutions of the East. Also he is anxious to give the commercial men an opportunity to demonstrate to him and others distant from the large eastern cities, new apparatus and inventions as they are brought out. If possible the supply firms should be permitted in the same building as the Conference that one may spend ten minutes or a half-hour's leisure time with them and their goods at any time available. What though it might take a few more from the sessions—if it should? The total good coming from the Conference would be only increased.

The non-commercial exhibit is an excellent feature of this Conference and should be increased and broadened as much as possible. The solutions of some of our most worrisome details are answered for us by others through these exhibits. There is scarcely five minutes during the days or evenings that from half a dozen to fifty of our members are not busy studying this exhibit and comparing others' with their own methods and apparatus. No word we can say in praise of this exhibit can be too laudatory of its importance.

Of the several persons offering suggestions for this paper, it was almost the universal cry that the smaller hospitals be given more consideration in our Conferences. All hope that this year will demonstrate how badly we of the smaller institutions need to confer with one another and how valuably our time may thus be spent. Perhaps two days next year may not be too much time to spend in separate sessions. Or, perhaps, another classification such as was suggested by Mr. Wells might be more profitable for the second day of separate sessions. Personally I would like to see one session turned over to the private sanitariums which have little occasion for attending these meetings or belonging to the Association for the reason that their vital problems are largely aside from those of most hospitals. If this organization can father such a movement as that, doubtless it will forestall the organizing of a national body to include sanitariums only.

A final point I would make is to have some systematic course of education started to encourage young women



in the pursuit of nursing as a profession. Many excellent young women are interested in nursing, others would be if they knew much about it. Few of them know how to get started at it as a student, unless they just happen to have talked to some physician. In fact about the only person to aid us in interesting young women in nursing is the physician. Magazine and newspaper articles and items should be written and information disseminated about hospitals and nursing schools. There is a dearth of desirable probationers and especially at the time of year most needed. This situation might be overcome by general education, at no expense other than the time and labor of writing. Newspapers will always be glad to use good articles for their Sunday issues. And magazines will pay well for properly written special articles or stories that will also have their educational and inspirational value for us.

Now, fellow members of the American Hospital Association, we have studied a few of the scores of things that are within the limits of possibility for our organization to do. All of the secondary points are practical and will doubtless be taken up by the Association as the way opens up. Also the permanent secretaryship and headquarters, the subsidiary organizations and the annual institute for hospital executives are changes seriously to be wished. Which ones if any are practical to take up at this time are for the Association to consider and decide if it chooses. That a larger field of work would open up through any one of the channels is unquestionable. Personally, the writer would be glad to see the question of an official publication as a means to a permanent secretaryship and headquarters thoroughly discussed and if considered practical at this Conference have one or more committees appointed to work out the different details in pursuance of this course.

There is a large field of unorganized hospitals and unsystematized, unstandardized hospital conditions in this country, calling this organization to control them. The time is soon at hand when the present system of disorganized conditions will be intolerable. Practically all other lines of human endeavors are better organized than hospital work. So much of the work being done

in the name of charity and its almost universal lack of means, perhaps accounts to much extent for this lack of aggressiveness. But surely this organization is now old enough and strong enough to assume these grave needs. I urge you members of the Association and especially those older and more experienced in the Conference's work to look seriously to the needs of the hospital world and shirk not your duty in the enlargement and betterment of this Association and its Conference in the interest of the hospitals of America.

#### DISCUSSION.

CHAIRMAN: This paper is now open for discussion. These are some of the headings: Permanent Secretaryship, Establishment of a Bureau of Information, Establishment of a Journal by the Association, Methods of Raising Money, etc. (Reading.)

DR. FOWLER: I enjoyed very much the paper read by the distinguished essayist from Kansas City and some of the points made in it strike me as extremely pertinent and practical. I believe that we ought to have a permanent secretary under good pay. I believe that is one of the ways of elevating this Association, the best way of all, that is to get direct information pertaining to hospital matters, and I am satisfied that instead of spending money in other directions, it would be better to spend it in that particular direction. I am also in favor, Mr. Chairman, of the essayist's idea of a Chatauqua summer school. Most hospital superintendents are too closely confined to their particular duties. They need getting together, and I believe if we were to select some central place where there was boating and fishing and all that, that most superintendents of America could attend and would attend, and I know it is entirely feasible to have the right sort of speakers and lecturers, because everybody is perfectly willing to contribute what they can towards the advancement of the American hospital, and I am satisfied that that feature would be a success.

About the expert promoter to raise money, I believe that is a splendid suggestion. I know down in my town every great civic proposition that is made, we have to bring somebody there to start the ball rolling, to teach us how to do the thing. I am satisfied that wherever there is a shortage of money in any particular hospital, or they want to make a hospital canvass for building a new one, where there was ample money in the city and they needed somebody to raise it, that an expert could go and do the work. There are men in this country particularly trained and gifted in that direction and I heartily approve of that idea.

Mr. Haworth also suggested that we could improve the nursing force by some series of advertising, like articles in magazines and journals. I have always had an idea that that was the proper way to do the thing. Most of the nurses that apply are

not women of education, because that character of women do not seem to know much about hospitals. It is only a little while ago that Sister Catherine sent over by Florence Nightingale, who went into the Bellevue Hospital, had to take her pupil nurses from the work house. We have overcome that, but still the finest women go into other avenues, which pay them less, because they do not seem to know anything about the training school and the grand work in nursing. In my own opinion there is no vocation in life as grand and noble as that of nursing, and I believe if some of the capable writers, as suggested by Mr. Haworth, would advance those ideas in magazines, that we would get splendid results.

CHAIRMAN: Under Section 7 of the Constitution and By-laws there is a paragraph which reads as follows: "The committee on the Development of the Association shall present annually a report on the further development of the Association's work." Unfortunately, for the last two years, for some reason or another there was no such committee appointed. I believe that committee was advocated by Dr. Goldwater in the President's address he gave some years ago. Mr. Haworth's paper is full of suggestions as to the development of the Association, and coming from one who has been thinking a great deal about these problems in three years past, it strikes me to be a good idea to have Mr. Haworth's paper, after it has been discussed as freely as you wish, referred to a committee appointed by the incoming President, which committee will take up the various points. It occurred to me that the membership of that committee, if I might make a suggestion, should be chosen from the past Presidents of the Association, from among the past Presidents and possibly Secretaries of the Association and perhaps the Treasurer. You might think of that suggestion.

DR. H. A. BOYCE: It seems to me that one of the greatest handicaps of our Association is the changing of our President each year. When we get a good President we should keep him for several years. He just gets interested in his work when there is a change.

In connection with getting nurses, somebody has spoken of putting articles in papers and magazines. I think that addresses given before normal and public school classes and college students would be of service. Then, perhaps, one would be able to obtain a class of women who are better educated.

As regards expansion of the Association, getting extra members and so on, it seems to me that it needs some one to go to the different centers and interest trustees. I believe all the different centers should be visited. Lectures should be delivered at certain seasons of the year on hospital topics of interest. Numbers of members would come to those lectures that are not able to come to these larger meetings held as they are in the East and Middle West. There are a number of people in the West who never come to our Association because it is a very long distance to travel and it takes some time to get here.

CHAIRMAN: Any other remarks or any questions to be asked?



MR. OLSON: Inasmuch as Mr. Haworth has seen fit to quote practically verbatim some of the suggestions which I wrote in reply to a letter from him, it might be up to me to defend them or apologize for them, I don't know which. One of the suggestions made there was that I think the membership of the Association is on a wrong basis entirely. We are merely a voluntary association of persons interested in hospital work. I find that the Bankers' Association is not constituted in that way, nor is the Hotel Men's Association constituted that way, nor the National Laundrymen's, or National Druggists' Association anything of that sort, but their association consists of firm memberships. If I have a bank in a town the Bankers' Association fixes the fee on the basis of my capitalization and then my bank sends a representative to the meeting and the bank pays the expense. It is not voluntary for me exactly, of course I can get out if I want to, but it is a business proposition. My theory is that hospitals should be organized much the same way and the American Hospital Association should mean something to the hospitals as well as to the individuals working in those hospitals. A card in a little frame should be hung in our office certifying that we are members of the American Hospital Association. It would raise our standard and put a sort of a label of character upon our institution and then the Board would pay the dues and should pay the expenses of the superintendent, or whomever they might designate as the official representative of that hospital to attend the Convention. They did that in my case, but there are more cases where they do not do it. They were generous enough to tell me, "You go down to Boston and New York and see anything you like and come back and present us the bill." This should not be merely an Association of individuals interested voluntarily in the work of the Association. Then the membership fee should be graduated according to the bed capacity of the hospital. I suggested that because in its logical sequence—on condition that Hospital Association really developed some valuable service, if it does develop some valuable service departments—then, of course, the hospitals will benefit in proportion to their capacity and pay accordingly, it having larger funds to do it with. I think that even cities and states might be made to see that it would not be misappropriation of public funds to pay that membership fee. I suggested the expansion idea. I know this Association has worked on this device, but I have not been approached by anybody who was equipped to instal such a system. I am an interloper in the hospital. I was for twenty years a printer and I am still very much of a printer when I am not busy in the hospital. It is an avocation with me now; but the printing business ten years ago was in a pitiful state and no printing establishments were paying dividends. Some expert who had received his training with the National Cash Register Company devised the printer's cost system and he made a fortune in introducing it, which he was well entitled to, because printers have been on Easy Street ever since, and you have not noticed an increased cost in printing, but the printer has, because the little device has brought him out of the mire and put him where he might be able to ride an automobile, too. Such a state of service might be

accomplished for the hospital. The idea of this man was taken up by the national organization and he was authorized to introduce it at each office and each office was charged in proportion to the number of men employed. That is what I would like to see in Hospitals. In looking through the books we have out there, there are different places and it seems to me some institutions are run for the benefit of the printers, and really some institutions I would like to go in to the business and make a contract to do the printing. I would make a nice revenue. There are too many forms and there is not much uniformity in the forms. That might be all simplified, and how much better it would be if we could use the same forms. If we are a large hospital we need greater variety than small hospitals. That is something we ought to do and then place the Association so that every hospital will be seeking membership and then pay according to its capacity and be very careful to continue its membership, so that its certificate of membership, like a doctor's license on the wall, will not be taken away from it.

MR. R. P. BORDEN: One thing occurred to me from the point of view of the trustee. For many years I have wondered why you superintendents go on and pay your five dollars and the hospital does not pay anything. Sometimes I understand that the Board is sensible enough to see that it does not cost you anything to go to the Conference, but I doubt if it pays your five dollars. Now if you have any influence with the hospital, and you ought to have some, why don't you make the hospital pay the fees to run this institution and then delegate you to go to it? There is no question but what it is a great advantage to the institutions that the superintendents represent, to have their superintendents come and listen to the very interesting papers and discussions that go on at these Conferences, and I do not think it will be very hard for you to induce the Boards of Trustees of your various hospitals to understand that point. I think the hospitals ought to be the members of this Association and that the superintendents and perhaps one or two of the trustees ought to be delegates to the Conferences. I do not think the Presidents of the institutions would be very much surprised at such an undertaking, in fact, I saw one president of an institution here day before yesterday, he was a new president and he said he thought he would come to represent the hospital of which he was president, because he thought the hospital was a member of the Association, not the superintendent. It seems to me it would be very easy and politic and business-like for you to adopt some resolutions changing the membership of this institution from superintendents and trustees of hospitals to the hospitals themselves.

DR. FRANKLIN (Dallas, Texas): I think the paper is full of good points from first to last. I think one of the things the reader suggests as to the permanent secretary ought to be put into effect right away. There are many points on which we need information immediately and we can get that only by having a paid secretary whom we can write on certain points that might arise at different times. With regard to the membership,

I do think the hospital itself should be the member and not the individual superintendent or trustee. There are many other good points brought out and I hope that we may see fit to adopt some of them by the time we meet another year.

CHAIRMAN: Is there any proposal as to what we shall do with the paper? Some of the speakers have spoken about the question of having a paid secretary. That raises the question of our finances and where the funds should come from, and I hope that my suggestions will be acted upon, that a committee be appointed or the incoming president be requested to appoint a committee to deal with this subject. It might be in order to suggest to the President also how this committee shall be constituted.

DR. FOWLER: I move, Mr. Chairman, that the President appoint a committee of three to take up the suggestions as made in the paper, to be reported at the next meeting of the conference. (Seconded.)

CHAIRMAN: You have heard the motion, which is seconded. Perhaps before putting that to vote we might hear from Mr. Haworth in closing.

MR. HAWORTH: Most of the speakers have spoken along the same line as my own. The purpose of this paper was to get our organization in condition in which it could make some progress. I was in hopes something could be done this year. The motion that has been put forth leaves another year before anything can be done. As I understand, that is the best that can be done under our present organization, but if we can get a permanent secretaryship, then we certainly can do something each year instead of dilly-dallying along as we are now and not accomplishing anything under any particular head under two or three years' time. It seems to me it is a waste of time, and I think a great many of the members feel the same way about it. I do not know of any way of getting along any faster at the present time.

DR. MOSSELL: I should like to make an amendment to the motion that Mr. Olson be made one of that committee of three, if the mover of the motion will accept that.

DR. FOWLER: I will accept that.

The motion was then put to vote and carried ,



## THE EMPLOYMENT OF THIRD YEAR NURSES AS SPECIALS.

MISS MARY ALBERTA BAKER, R.N.,

Superintendent, St. Luke's Hospital, Jacksonville, Fla.

This subject concerns a phase of hospital life about which, I am sure, every hospital superintendent has strong convictions. Generally the conviction is the result of individual observation, as well as intelligent study of the experience of others. It is approved or not and seems to admit of little argument.

If I had been asked for a paper on, "The Problems of Special Nursing" or "The Graduate Nurse on Hospital Duty," or a "Study of the Comparative Value of Graduate and Under-Graduate Special Nurses," I might have had something original to contribute, but as to "Pupil Nurses as Specials," it seems exceedingly presumptuous for me to express before this Association any views I may have upon this very practical subject. I am sure I can say nothing that has not already been much better said. I know much has been written. Our journals devote much space to discussions of the problem, thereby confessing the existence of a problem. Miss Aikens has written much that is stimulating and helpful. All papers on hospital management devote considerable thought to the subject. This paper is almost controversial in the stand it makes against the usual method of special nursing in hospitals and any value it may have must come from the discussion which is to follow.

We may make one statement to which every one may subscribe. Hospitals, though conducted for the benefit of many people, from owners or officials to the humblest employees, for the carrying out of educational, business, charitable and humanitarian obligations, are in the final analysis *primarily* maintained for the benefit of the patient. The true relative value of other issues must be kept well in mind. Hospitals differ so radically in structure and aims that it is quite impossible to make

one single statement regarding the justice, advisability or advantage of using pupil nurses as specials, that cannot be met with sincere and valid objections. The larger hospitals, few comparatively in number but powerful in moulding nursing theories, generally confine their specializing in graduates of their own schools and strongly disapprove of giving pupils this service. The smaller hospitals, for obvious reasons, if they are fortunate enough to have a sufficient number of pupil nurses, quite generally follow the established precedent of using their senior undergraduates as specials. They take very kindly to this use of the "Girls we Train." Their boards of governors, and doctors as well, expect their nurses to in this way contribute to the income of the hospital and the pupils themselves see no aspect in their so doing other than securing a good opportunity to avoid hard work and to build up for themselves an advantageous clientele. I have not as yet found the pupil nurse, who, as the finished product of even an ideal training school, represents to my mind the *n*th power of efficiency, as a result of training alone. Can anyone after two or three years hope to attain the pinnacle of perfection to which everyone seems to measure the graduate nurse? Personality, education, breeding, plus her training make a nurse exceedingly valuable. Training can never compensate for lack in these essentials. Superintendents who have not sufficiently considered the seriousness of these defects are largely responsible for the class of graduate nurses whom the hospitals have learned to regard with dread when employing them on special duty.

I insist there is no royal road to specializing private cases, except the old and tried path of experience. Nurses must have private patients in the hospital if they expect to have private patients outside the hospital, which seventy per cent. do. Theory or example can save the pupil graduated. She should have been taught by a head nurse and personally conducted through the phases of nursing one case.

#### OBJECTIONS TO PUPIL NURSES AS SPECIALS.

Objections to the use of pupil specials are legion, but the potentialities as well as the actualities of their service in charge of single private patients make the

refusal to give them the opportunity only comparatively wise. The objections are well known. The criticisms that are made are familiar ones. The patient does not secure efficient service unless the pupil is closely supervised, which makes the proposition an expense instead of a source of income to the hospital. Again the pupil loses most valuable routine training and instructive services in other departments of the hospital. She fails, therefore, to secure the technical skill which comes from practicing certain nursing technique so essential for a pupil to acquire through continuous work in the wards. Again she is not competent to meet the situations such specializing develops. She has never studied psychology and if entirely inexperienced, even personality, education and breeding will not always safely guide her. Another familiar criticism is that as she becomes a source of income to a hospital, an undesirable attitude toward those who are set in authority over her is brought about and frequently leads to serious insubordination through her reasoning that she is doing the work of a graduate and should enjoy the privileges of one. Patients occasionally regard the specializing of a pupil nurse as an unfair intent on part of the hospital to secure for itself an income which should from a business viewpoint go to a class of women who have been trained by perhaps that same hospital for just that special work. Again, the fact of a pupil nurse earning for her hospital argues that she has a genuine earning capacity and, as generally she receives a very small compensation or none at all during her training days, the ethics of using her time in this way is a very nice point. These arguments all find many advocates.

Hospitals having only private patients, employing only graduate nurses, present a simple problem. They may select free from all pressure the nurses they employ and succeed in making such employment most desirable. Hospitals having private cases only and maintaining a training school have a comparatively simple problem. They either employ their own graduates or their own pupils and are almost invariably satisfied with the results. Hospitals that accept the care of private, semi-private and ward patients under the condition of only fair equipment are the ones to whom this problem of special nursing is acute.



### NURSES FIVE YEARS AFTER GRADUATION NOT THE EQUAL OF THIRD YEAR PUPIL NURSES.

I may as well state broadly at the start that the average graduate nurse five years after graduation, unless she has been fortunate enough to have had the privilege of much special nursing in a hospital, is not the equal of a third year pupil in the nursing technique and skill commonly required to properly care for cases which a physician or surgeon considers necessary to bring to the hospital. She has lost through lack of practice much that she possessed, though undoubtedly richer in many ways. She has rarely any feelings of loyalty or devotion to the hospital, its traditions, methods or its doctors, and is much given to telling the pupil nurses how things should be done. She indulges in much visiting, criticisms, and shows lamentable lack of wisdom and dignity. Take a hospital of one hundred beds, place in its private rooms twenty special graduate nurses from all over the country, and the effect is appalling and very nearly demoralizing. Formal rules for the guidance of specials save much trouble and have been adopted by many hospitals. St. Luke's in Jacksonville, Fla., has for five years had a practical set for reference; Grace in Detroit has a very complete form. Dr. Hornsby's new book, "The Modern Hospital," has a most pertinent list applicable everywhere. While large hospitals can easily control this question, the smaller ones cannot successfully assimilate it. While there is no doubt that the graduate nurse is the efficient trained woman the world over, it is doubtful if she has cultivated as assiduously as is desirable the courtesies, tact, adaptability and loyalty that makes her the best available special nurse in the hospital. Her experience cannot be equalled by any pupil nurse. The personal equation enters here and decides either for or against the graduate. Is this greater experience counterbalanced by the loyal devotion of the pupil nurse to the hospital, its officers and doctors, and her enthusiastic desire to make and keep her patient happy and absolutely assured that the institution which is caring for him is the best organized and administered one in reach, that its service is excellent and that every individual connected with the hospital has a warm desire to secure his comfort of body and mind? I think it is. Where

the pupil has the ability behind her enthusiasm the count is always in her hospital's favor. The service required in some cases may not be of a character beyond the ability of a pupil to achieve. Technical skill is not always demanded. The expense of a graduate nurse may be an impossible one and granted that the pupil has the same supervision to which she is entitled on the wards, will she not be sufficient in a large number of cases? Add to this always a comprehensive system of case instruction from the doctors in charge and what could then be more eminently valuable to the nurse and satisfactory to the patient?

#### BEDSIDE INSTRUCTION IMPORTANT FOR PUPIL NURSE.

Doctors are not always sufficiently alive to the teaching opportunities of many of our training schools. Bedside instruction is more likely to be the portion of an interne in a ward than a pupil nurse on special duty. The need of such instruction is becoming more apparent every day. Where the policy of employing pupils as specials is adopted this method of teaching will be proven the very best, and with careful teaching the actual gain in knowledge to the pupil is inestimable. Such case instruction must not be offensive to the patient and can be accomplished without consuming many minutes of the busy doctor's time. The more intelligent his nurse the more is an intelligent doctor pleased. Always he is willing to teach, but a good system must be adopted and followed persistently. Case instruction, specialing and supervision are excellent and important parts of a general nurse's training. I do not consider it time lost from ward routine, study and duties. It is a very necessary and practical service, holding promise of safety in the troubled waters of private nursing for years to come.

An experienced nurse encounters endless problems in her work. The family, friends, relatives, home, children, cook, finances, all must at times be handled with quiet skill. She is supposed, in the disorganized condition of a household in which the mother is ill, to bring order out of chaos, to achieve all the mother's many duties and special a sick patient as well. The babies and home she must control to secure her patients peace of mind and assist her recovery. Can a nurse trained

in a city hospital for instance, where there are only ward patients, hope to cope with such a situation? If she is the right woman and by grace of God endowed with intelligence, industry, tact and a passion for serving others, she may, but she could do it better if she had been taught how to meet the situation by specializing in her hospital training. I may go further and say that she could do it still better if she had learned to do it in the homes of the sick and had been given a service under a social worker. Ward nursing and specializing are as far apart as the poles in requirements, and I contend specializing is as necessary as ward work to develop the ability to handle successfully the private patient. Pupils will be very easily made to realize that specializing does not make a graduate nurse. Regular twelve hour duty, rigid supervision, technical and practical instruction will prevent any leaning toward insubordination. She is more apt to be very jealous of her good behaviour and make a praiseworthy effort to secure approbation.

Graduate nurses will always be needed and always gladly welcomed. Their income would scarcely suffer if all hospitals employed only pupils, but there must be some woeful lack in our training ideals that make it necessary to select with such infinite care the nurses the average superintendent cares to bring in daily contact with her pupils. They are fine women but the sum total of their value in a hospital is not proven to be that of a carefully selected pupil nurse. Until this attitude of superiority is completely changed I think this field of activity will not be undisputed. Nurses some time look back upon their training school days and bitterly remark that they earned hundreds of dollars for their school. Why not? Most hospitals give charity service out of all proportion to their income. The private patient if properly maintained is a source of revenue which may be diverted to charity maintenance. Surely the small sum collected for the pupil's service is a legitimate asset for use, as certainly as her exercise of economy makes an addition to the hospital's income. Her training, not her salary, is her compensation and the use of such ability as she may possess to increase the finances of her hospital is advantageous to her personally. This is all not new. Specials we must all have



at times. The doctors have very positive prejudices regarding perfectly good graduate nurses. The dietitian collides seriously with one; another flirts with the junior interne; another manages to acquire a complete compendium of information after one hour on duty; still another walks heavily and talks aloud; another is always late on duty, again one has endless phone calls, and so on ad infinitum. Patience and discipline plus definite rules for their information can generally bring about a moderately smooth state of affairs, but for general hospital efficiency and smoothness of operation, for the happiness and contentment of officials, nurses, employees and patients the better way is to eliminate the graduate special, secure a sufficient number of pupils, train and discipline them into good efficient nurses and give them the service of caring for private patients under proper conditions.

#### DISCUSSION.

CHAIRMAN: You have heard Miss Baker's excellent paper, now for the discussion.

DR. FOWLER: I should like to call upon Dr. Harris, of Battle Creek Sanatorium.

DR. R. B. HARRIS (Battle Creek, Mich.): What I have to say is based upon experience as assistant surgeon having the after care of surgical cases where we use practically only special nurses. We have in our wards separate rooms at the particular time the patient is in need of nursing, the patient has a special nurse day and night, but after the patient is able to do with less care, we have a system of what we call general nursing, the patients are cared for by nurses who go from room to room under the direction of the head nurse. I quite heartily agree with everything Miss Baker has said. She said that large hospitals disapprove of graduates as special nurses, and I think I agree with that also. I find that third year pupil nurses give better satisfaction than the graduate nurses, and I think that the reason of it is that they are loyal to the institution and they are anxious to please the doctor, they are still looking ahead of getting a diploma and they wish to have good records with all their work. I do not think it is unfair at all to the pupil nurse to have her as a special nurse, because she receives training that she cannot otherwise get. She is more closely checked up and more carefully watched as a special nurse than she could be in a ward. As a special nurse she is held accountable for every detail of the record and every detail of the treatment. When the doctor comes around to the case, he considers the case carefully, looks over all the records the nurse has made, and if the nurse has made a full record the doctor can tell immediately

whether the nurse has done what she should. He can also tell just the condition of the patient and he is in position then, with just a glance at the chart, to give the nurse valuable instruction, to tell her quietly what things should have been done differently and to give her good instruction as to what to do in the succeeding time. I believe that the pupil nurses are more in touch with the methods in use in the hospital than are the graduate nurses. The graduate nurses many times return after an absence of four or five years or longer, and personally I feel that I would rather have a pupil nurse work under me than to have a graduate nurse, because I do not feel quite so free to instruct a graduate nurse as the pupil nurse and to require as much of her. There are some who will disagree with what I say, but I say, I am taking the point of view of one who has nurses working under him, I might say I have from 30 to 40 or 50 nurses working under me the year round, and I have both graduate nurses and pupil nurses, and I have a chance to compare them every day. I will not talk further on the subject except to say that I quite heartily agree with what Miss Baker has said.

MISS ABBE: Mr. President and Members American Hospital Association: Like all other hospital problems the question of whether or no the pupil nurse should justly be allowed to special in the hospital has many sides from which to be viewed. In many ways my experience forces me to agree with Miss Baker, who has just presented her paper. The decision, however, must rest with the superintendent, who knows all the conditions of the case. The needs of the patient, also financial standing, the doctor's peculiarity, the strength of the hospital nursing force, the adaptability of the graduate or pupil to be employed, all must be carefully considered before a just decision can be made. In large or small hospitals where their own graduates are available and thus loyalty and order can be better maintained, all well and good. In the small hospital where outside graduates must be employed in many instances, the patient's financial circumstances and needs must be considered. I once had a doctor insist upon having a graduate special for a normal case of double hernia, which I believe could have been cared for by a careful pupil nurse. This patient was a part pay patient and the last I knew still indebted for the care he received at that time. In another instance, the doctor would not order a graduate special for a critical appendectomy on account of the patient's financial standing. The hospital force being inadequate, I called a graduate special at the expense of the hospital. Other patients are nervous at the prospect of an operation and the entrance into the hospital and believe that they cannot be left alone for a moment and therefore must have a special. With tact these patients can be made to have confidence that the hospital will give them all the care they need and no special at all need be employed. To my mind there can be no set rule by which the problem can be decided. I should like to add, however, that I am in favor of giving special nursing to all pupils expecting to do private work and who seem naturally fitted for that work, as well as to give the naturally inclined surgical nurse extra surgical training as long as it does not interfere too seriously with the regular routine of the hospital. Another point

that might be mentioned is the question of compensation for such service, the amount and to whom does it belong? My answer would be to the hospital who cannot in justice to the other patients give such care without extra charge, and not to the pupil, who can never repay the hospital for her training. Therefore I argue that the question of allowing the pupil nurse to special must be decided by the one in charge as the case demands, after a careful consideration of the natural ability of the nurse, also the disposition of the patient and financial standing and attention he would demand, the strength of the hospital force of nursing and the wishes of the physician in charge.

CHAIRMAN: Any one else who wishes to make some remarks upon the paper.

DR. BOYCE: My idea was that this involved the necessity of having an extra number of pupil nurses. If so, I can see it is an advantage in this way, that is, it lessens the work to a certain extent of those who are already there or doing the work in the hospital and it is a source of income, as we have already heard, to the institution. We have heard a great deal of pupil nurses being overworked. If the hospital had five or six extra nurses available as specials when required this would lessen the work on the others.

CHAIRMAN: Any further remarks on Miss Baker's paper? If no one else will speak on the subject that completes our program for this afternoon. As we have another session this evening we will close now, to give an interim for rest and refreshment. By looking at the program for this evening you will see the list of subjects for discussion. If you are particularly interested in any of the subjects and will kindly leave the name at this table before the meeting adjourns, the Chairman tonight will be pleased to call on the persons who are so designated.



## WEDNESDAY, AUGUST 27—EVENING SESSION.

## ROUND TABLE CONFERENCE FOR SUPERINTENDENTS OF SMALL HOSPITALS.

DR. J. N. E. BROWN, *Chairman.*

## GENERAL ADMINISTRATION.

CHAIRMAN: I understand Dr. Washburn will not be here, and if Miss Morrison is here we would be glad to have her preside. If not, we will have to stumble along as we did this morning and this afternoon. We thought it would be better to get a little nearer together this evening and try to make the meeting as conversational as possible so that you will feel free to discuss the subjects on the program. If those at the back will come forward and those at the edges will bring their chairs around a little closer, I think you will hear better. We will not take the questions just in the order in which they are found on the program, but start lower down and work up.

Topic No. 6.—*The employment of nurses in preference to internes, as anaesthetists.*

CHAIRMAN: Miss Jordan will open the discussion. She is not here yet, and we will have her remarks later. Now all the hospital superintendents here have either doctors as anaesthetists, or nurses, and we would like to have your experience, especially those who do not employ doctors. In some of the hospitals that I know of they employ nurses as anaesthetists, Mayo Brothers, in Rochester, Minnesota, and others. I saw Dr. Crile operate in Cleveland the other day and there was (I think) a nurse giving the anaesthetic. To digress from the question a few moments—I was very much interested in the anaesthetic, simply because Dr. Crile's methods of anaesthesia are world-wide. Dr. Moynihan the other day at the British Medical Association, one of our best British surgeons, gave a great deal of his paper to the discussion of Dr. Crile's methods. Dr. Crile, as you know, practices what is called the Anoci Association methods—a word invented by himself. Briefly they consist first of all of giving the patient an injection of morphia and atropine. The patient comes to the operation with the greatest confidence in Dr. Crile himself, one of our most skilful surgeons of America; is put in the proper mental condition, so far as the anaesthetist and surgeon operating is concerned (which means a great deal). As Dr. Crile proceeds with his operation he injects into the skin and into the muscular tissues and into the peritoneum, novocaine. It was surprising to me to see how many injections he gave. They were admin-

istered rapidly, the nurse standing by holding the syringe ready for him. When the operation is over he follows up by another injection of morphia and atropine. The general anaesthetic is oxygen and nitrous oxide, the patient is under in a few moments, and just in a very few minutes after the anaesthetic is discontinued, the patient is out from under the anaesthetic and lively as a cricket—no nausea, no bad after effects whatever. Dr. Crile's theory is that many patients without such precautions suffer injuriously from shock of the nervous system. His idea is that that shock may be caused by the ether, chloroform, or whatever anaesthetic is given, and it may be further increased by the incisions made in the abdominal wall, or by the manipulation of the intestines. What he has written on this subject is very interesting indeed and his method is being tried out by a number of surgeons in America and in England. I did not mean to answer this question myself; I hope Miss Jordan is here. Well, Miss Jordan is not here. I am sure there are many of you who would say just a word on this subject, it is open for discussion.

MISS HARRIET HARTRY (Minneapolis): Inasmuch as I think each year since this meeting was held in Toronto I have said something about the nurse giving anaesthetics, I did not expect or intend to say anything here, but as no one else seems to care about starting, I thought I would say that the nurse who was appointed at St. Barnabas Hospital six years ago to give anaesthetics is still giving them, that she has given several thousand anaesthetics now without any ill effects, and I want to speak not only for the hospital I represent, but for all the hospitals in the Twin Cities—Minneapolis and St. Paul. I believe every hospital, including the new University of Minnesota Hospital, employs nurses as anaesthetists. It seems to me that the reason for this is that the interne does service there for only three or four months, that he expects, or ought to, to be a surgeon, and he is more interested in watching the operation than he is in watching his patient. I am sure those of us who have stood in the operating room year after year and have watched the new interne come in and attempt to give anaesthetics have no hesitation in saying that a woman, a nurse preferably, who is trained to give anaesthetics, will give them more intelligently than the interne who is just there two or three months.

DR. FOWLER (Louisville, Ky.): I entertain such a radical opinion, it is so different from the speaker who has just spoken and from the general idea of an interne or a nurse giving the anaesthetic, that possibly I will not be harmonious with the proposition. I do not think that either an interne or a nurse is capable of giving an anaesthetic, and I voice in that proposition the voice of the American Medical Association. They claim that no nurse lives, or interne, who has had sufficient experience to be an anaesthetist. They do not understand anatomy and physiology sufficiently to be competent to do that service, and it is suggested by the American Medical Association that it is just as important that the anaesthetist should be

a first-class physician and staff officer as any other branch in the entire field of medicine, either surgery or any other particular branch. It is our own hospital in Louisville, Kentucky, where we have 300 beds at present and 600 beds in our new hospital, we have two services, a winter and a summer service, and in each of those services the anaesthesia is placed in the hands of the staff physician who himself is present at all the operations, and I think myself that that is the only way to do it.

DR. P. E. TRUESDALE (Fall River, Mass): I think the previous speaker will find that there is a very decided opinion to the contrary with regard to the ability of nurses to administer ether, and I question very much just how far the American Medical Association—I am a member of the Association—will go in this direction, but there is a movement in the State of New York to eliminate the nurse entirely from the position of anaesthetists and whether that is altogether a sane movement or not remains to be proven. When Miss McCall, of Rochester, Minnesota, published her paper about three or four years ago, reporting 15,000 cases of anaesthesia, I think that that to any mortal is sufficient argument, at least it is for me, to convince me that the nurse has a place as an anaesthetist. (Applause.)

Why should not the nurse be a good anaesthetist, if she is properly trained by temperament and by intellect? Because she has certain qualities that a man does not possess, and just as soon as the patient lies down to take his ether, if he is a man he gives up to the nurse, but if a man is going to administer that ether the feeling of resistance and fight is in him, and it stays in him until somebody puts their knee on his chest and he is overcome. Now, then, the nurse has a place as an anaesthetist. Moreover, if she devotes her whole time to anaesthesia she does something that men physicians will not do or, internes. They devote very little of their time to anaesthesia, most of their time is devoted to something else. I have employed a nurse as an anaesthetist for eight years, one for the last five years, and it is exceedingly difficult just now, in her absence for a few months, to find somebody to take her place. I have tried several and nobody is equal to it. Of course there are expert anaesthetist men, but the question here is, shall the nurse or the interne administer ether? I can take it a step further than that and say, the nurse or the physician, I think she is equally capable, and, to come right down to Dr. Crile's proposition of the Anoci Association, his success is very largely vested in Miss Hodgins.

DR. JOSEPH B. HOWLAND (Massachusetts General Hospital): I think there is something more to be said. In these days anaesthesia means a great deal more than simply giving ether or giving oxygen. We have in the Massachusetts General Hospital a department of anaesthesia, the head of that is a trained anaesthetist, a physician who does nothing else than decide, the hospital giving the anaesthetic. He has an assistant, a man who is a physician, who is there when he cannot be there. There comes a question of just what anaesthetic shall be given.



That is not a nurse's duty, it is a trained anaesthetist's duty, but having decided that, those cases are turned over to a nurse anaesthetist, and so far as our experience goes they are the greatest possible success. They do not usurp the physician's place, they are a valuable aid, but behind that must be the physician expert to go over the heart and lungs before he will finally decide what shall be used.

MR CHARLES H. COOK: It occurs to me that the question should go back to the medical schools, as to whether in the medical schools the students are taught to give anaesthesia as they ought to be taught. It was my privilege to sit under Samuel M. Kale, of Bellevue Medical College, and he taught us how to give anaesthesia and he dwelt especially on the point made by one of the speakers here, that so many are watching the operation instead of giving anaesthesia and he told us that our sole business was to give the anaesthetic, not to know anything about the operation, not to know what was being done, that we were the most responsible of all, that the patient's life is in our hands and that the only thing we had to do was to watch that patient. That is the only right way for teaching anaesthesia. Will your medical students be taught that in your medical colleges, will your nurses be taught that in your training schools?

Now I want to tell you a story. Dr. Louis A. Sayre, the noted surgeon, was a great advocate of chloroform and he claimed chloroform, properly given, was just as safe, or even safer than ether. He was not allowed to give it in the wards of Bellevue Hospital because it was against the rules, but he did give it to his private patients, and Dr. Yale was his anaesthetist. "Now," he said, "you watch Dr. Yale, and if you will give chloroform as Dr. Yale says and as he does, your patients will be perfectly safe and there will be no danger." In the spring recitation course when Dr. Yale was giving the anaesthesia instruction, it came to a surgical operation before the students in the recitation course. Of course we expected to see chloroform administered, Dr. Yale was to operate. He remarked very quietly there was a legend abroad that Dr. Yale gave chloroform to his patients, he said: "Dr. Yale gives chloroform to Dr. Sayre's patients but he gives ether to his own." (Laughter.)

CHAIRMAN: Has anyone else anything to say on the subject? If it is not too much trouble, I am sure all the rest of the members would like to know in how many of the hospitals represented here ether is given by the nurses. Will the representatives of such hospitals kindly stand up, to see how common—Thank you.

Topic No. 2.—*Is a preliminary course feasible where the high school standard for admission has not been fully adopted?*

MR. BORDEN: May I make a suggestion that there are a great many people in the back of the hall very anxious to hear what is

being said, and if everybody would try to holler while they are in front, we might hear better. I will state that in my experience in listening to the girls in school that they were just as able to make as much noise as the men. If they would only try to do that tonight it will be very agreeable to this audience.

MISS BLANCHE M. THAYER (City Hospital, Quincy, Mass): There is no question in my mind but that a preliminary course would be an excellent thing for such pupils as have not had the advantage of a high school training, but I think it is a very difficult thing to determine just what this training should consist of. There seems to be a great difference of opinion. Naturally one would think that it would cover such subjects as the ones we naturally get in high school training, chemistry, physics perhaps and in addition hygiene and bacteriology. A theoretical training of that sort would fit a pupil to pursue the study of nursing intelligently. I think that is what this course should consist of. But it seems to me those should be studied very thoroughly and should be decided on and it should be, of course, adopted, each school should have the same course prepared for it, it should be done by some association of this sort, and the same course should be used by each school, and not each school have a course of its own. I think that is the way in our training school today, there is no uniformity of training. It is one of the great and important things which should be. Some one has suggested this practical course given in training schools might be made to do duty as a preliminary course, but that seems to me to be a regular part of the training and this should be theoretical and something which should help the people toward the study of nursing.

MISS PERRY: Miss Thayer said practically what was in my mind. During the past winter our States' Association has tried to bring about a uniform curriculum, and it does seem very necessary that we should have our standards settled, and I do not think we can ever get them settled until we get our hospitals registered in Massachusetts. As a matter of fact, the Massachusetts hospitals have to register in New York and in New York one year of high school or equivalent is a minimum requirement. If we decide to have the high school course, or not to have any requirement, then I should think under any circumstances, whether we do have it or not have it, I think a preliminary course is a very helpful thing. There is a great deal of ignorance as to what the life of a nurse is, what the training consists of, and anything that could help one for the future training would seem to be a good thing. But we do want to start out with the idea as to what this preliminary course is to consist of and we should have our standards set in order that we may know what to require of the nurse. If we can have a uniform preliminary course, I should think it would be a very good thing. Having so many ideas on the subject would seem rather confusing and a uniform preliminary course and a standard of requirements would be very helpful in our training of nurses.

CHAIRMAN: We will pass on to No. 3.

Topic No. 3.—*What are some of the advantages with paid instructors for the lecture course in training schools?*

MISS PARSONS: We can all doubtless recall many splendid lectures and bedside talks from the instructors who have given their services for the love of the work and interest in the schools. I suppose most of our schools still depend a great deal upon this voluntary work, and I would not underestimate its value. Every time we are fortunate enough to find a person, man or woman, who has the ability and the interest and the time to give to this work, who will give it as conscientiously as a paid instructor, the school may be thankful. But the advantages of having paid instructors are really so obvious that it seems almost superfluous to discuss it, especially the advantage of having resident paid instructors to supplement, perhaps, the lectures that are given gratuitously by the members of the hospital staff. When we pay for a thing we are allowed and are expected to be critical of the things paid for. We may demand quality and pick and choose the kind of service that shall be rendered. Under the non-payment system of instructors we not only remember those who have given perfectly good service, but we can think of the many engagements broken; many of us can remember of the times we have been to lectures and have waited ten to fifteen minutes and then have heard the announcement that Dr. So-and-So was called away, or perhaps that he had forgotten his engagement and the class was dismissed and there was a week wasted as far as the school's program went. Then we can remember the very technical lectures that we have listened to, far over the head of the pupil perhaps, also the superficial lectures that have skimmed lightly over the surface, where it is perfectly evident that no preparation had been given to the work, and the uncertainty of such service is what renders it undesirable. When we can pay people who have not only the medical knowledge, but also the gift of imparting it to pupils, we are fortunate, and the value of the resident instructor who has had special preparation, who can supplement the lecture work, can meet the nurses' needs, impress upon them the most important facts that they should know, can find out what their mistaken ideas may be, answer questions for them, we are getting good work and we get good results. Such an instructor presumably has time to prepare her lessons beforehand, we know how she is going to handle her subject and to get ready her illustrative material. She can meet the nurses at the time that it is convenient to call the nurses together. In our school we have found one of the most advantageous features of paid instruction to be the fact that we are not obliged to call our night nurses up at the time it used to be necessary when we did not have the paid instructor. We can have a class for the day nurses and then an afternoon class between five and six for the night nurses. The instruction then is coherent, one thing fits into another, there is a definite plan that is followed out, and the value of having a paid instructor for practical



work is just as valuable as having a paid instructor for the theoretical work. Such an instructor is presumably an expert in her line. She studies various methods, she visits other schools, she studies the principal needs of her own classes, she knows the individuals in the classes and then she develops the work and develops the abilities of her pupils, she takes especial pride in the results that will be produced. It is all so different from the haphazard work that we used to do when paid officers, to be sure, but officers with other duties that were so exacting that it left them no proper time to prepare for class work, that we wonder how we ever got along without our paid instructors.

DR. COOK: I should like to inquire as to the expenses of a paid instructor.

MISS PARSONS: The doctors who come from the outside to lecture I believe are paid usually at the rate of from \$3 to \$5 an hour for their services. I will say that that remuneration is not considered really adequate for the value received, but the young men who give the lectures usually consider that experience in teaching is valuable to them and they can afford to give time to the work for this small remuneration. It is possible to get trained nurse instructors, those who have had special preparation for the work, for a salary varying from \$75, or perhaps \$65, to \$100 a month, with maintenance.

DR. KAVANAGH: This question is solved to a considerable extent by employing graduate nurses who are specializing in this particular field, and our nurses now are preparing for this work just as there are dietitians that make a specialty of visiting hospitals and giving class instruction, or that are taking nurses through the various branches of bacteriology, anatomy and physiology. Last year in our hospital we engaged a graduate nurse for this special business to visit the hospital twice every week, I do not know how many weeks, beginning perhaps in September, running towards February and March, and carrying classes through each particular subject. This is a woman that gives instruction in half a dozen hospitals, makes it her business. The work is useful, not beyond the reach of any of us, but her work was of a very high order, so that the class from the beginning to the end of the course regarded their work with very great enthusiasm, because of the ability of the teacher to impart information. The teacher would say something like this, "It is up to me to teach the girls so that they will not have to study much in their rooms." She said that they have work enough in the hospitals and it was for her to do the worrying for them for that hour. That is perhaps an extravagant statement. I would not want that to be taken literally, but it was practical work, and the work that she did was done so completely and done so well that it did make it much lighter for the girls when they were off duty than heretofore. We have engaged her for the same work this coming season, only this time she will give but one study in the week, because we wanted a certain hour where the night nurses and the day nurses could meet and the night nurses not be called in order to do their class work and that is the only way to work it out.

I think two hours in a week would be the right thing if we could get it, but the one hour a week was what was thought best.

We have had another practice that has also worked well. The supervising nurse, the assistant supervisor, has been selected by us frequently because of her ability in that particular line, and our present supervisor is very anxious that her assistant shall be the teacher of the course, perhaps that is general at the other hospitals, I do not know, but with us she is to be practically the teacher of the staff and so for several hours each day for several days in the week, how many I do not know, but for several days in a week she spends several hours with the girls. She may have but a few, four or five, that she is dealing with at once, after the first few weeks of preliminary training, and then she will take them into the ward and there they will learn from actual experience with the patient before them what this experienced nurse can teach them. There is a great deal that the young girls can learn in that way. Much of the work that is done by lecturing physicians and lecturing surgeons has been taken over by those that are thoroughly prepared and know just about what to teach the girls and to do it with the least amount of time and least amount of worry for the pupils. We are finding that that method is working well and is popular with the school. So popular was it in the last year that when we got through with this regular course, they all joined in and for about six lessons reviewed all the work that they had been doing the last year or so before we allowed them to go on and take the last examination.

MR. WALL: I should like to ask the last speaker if he could give us some idea as to the averages and the passing ability of those nurses before the state boards, who are instructed in anatomy, bacteriology and physiology by trained nurses.

DR. KAVANAGH: I would say we sent up a class, graduated a class of about 30 to 35 who were of the regular school and four or five post-graduates. All those girls that were graduated in time for the examinations, all of them passed, four or five passed with seals, whatever that means, I do not know, but the girls thought a great deal of the seals when they arrived. I want to say further something I omitted. Our doctors are also requisitioned for work, they are not excluded. For instance, one of our surgeons has a course of twelve lectures upon surgery; our obstetricians take a nurse through a course of I do not know how many lectures, they are not excluded, but we have to require less of the doctors in these particulars, we do not want to require too much of them throughout the season. We will get better results and we are going to please the doctors better. Without any question a well-trained woman who is a teacher, knows what to teach the girls that come before us every day, will give the best results.

CHAIRMAN: I should like to know how many hospitals have trained instructors in training schools. All those representatives who have paid instructors kindly rise to your feet, that we may get an idea of how common the practice is—23.

Topic No. 10.—*How best to secure the loyalty of nurses?*

MISS MINNIE GOODNOW: There are two or three requisites for securing loyalty, one, you must be absolutely loyal yourself. Everybody imitates the superintendent and the superintendent of nurses, they set the pace for the hospital. If you are not down deep in your heart unflinchingly loyal, you cannot expect your nurses to be. Then, again, if you find two or three disloyal nurses or head nurses, anyone in your hospital that is disloyal, get rid of them. You must, you cannot afford to keep them, no matter who they are, they will infect the whole hospital, it is not right. Then give your nurses something to be loyal to. If you are maintaining poor methods, if you are allowing inefficient surgeons and inefficient doctors, medical men to practice, men who are getting poor results, your nurses cannot be loyal to them and you cannot make them to be loyal. If you are yourself not giving your nurses proper training, if you are not giving them the right kind of classes. If you are not giving them as many classes as you should, if you are not giving them all the training that they ought to get, if you are not doing for your nurses what you ought to do, they cannot be loyal to you. You must do your part and they will do theirs.

Topic No. 7.—*The social side of training school life.*

CHAIRMAN: Perhaps some one here will volunteer to say something on the subject. I am asked to call on Miss Riddle, of Newton.

MISS MARY H. RIDDLE: I am not sure that I have anything to offer excepting this, that I think we all should pay more attention to the social side of our training school life than we do. Just how that is to be worked I cannot be quite sure, but I know of a school which has lately installed an officer with that purpose, and I am very sure that that officer is expecting to get some ideas from this meeting tonight. I am sure also that the larger schools which are represented here have had greater advantages than we have in our smaller schools, especially those of us that are in the country, and so I should be very glad to hear from some of the other members.

CHAIRMAN: Can we have half a dozen sentence experiences?

MR. OLSON: The social side of the training school life. My friend, Dr. Kavanagh, said if you have a good set of internes that will take care of itself. (Laughter.) But speaking seriously on the subject, I should say that more attention should be paid by hospital managers to the social side of training school life. You know that under the stringent rules in effect in most of our training schools, and in all of them perhaps, there is precious little sociability or time for sociability for training school pupils during the three years that they spend in our institution. We have a small training school, only 50 pupils, but still we try to make it very interesting for those pupils without in any way lowering the



standard fixed for a hospital. Our board feels very kindly towards those girls and in the first place has provided a very nice home for them, with sumptuous reception room and dining room particularly, rooms that can easily with a little decoration be fixed up and made to look very holiday-like at any time. The nurses arrange their summer festival about mid-summer, sometimes it is about the 24th of June, which is a great day with the Scandinavian people, just as with the French, and at Hallowe'en they have a party and at Christmas have a great time. The staff contributed last year about one hundred and eighty dollars which was placed in my hands to provide for the Christmas celebration at the hospital and it meant a very fine evening for them, good presents for every one. Then the nurses themselves are allowed in the summertime to arrange a lawn fete on the spacious lawn surrounding the nurses' home, to which they sell tickets and raise money to purchase some things that they want in the nurses' home. Last summer they raised in one evening money enough to purchase a very nice piano to match the woodwork in their reception room, which is in Flemish oak. They bought a beautiful piano and they had a good time besides. Then when it comes time for graduation of the senior classes, our board always gives a reception to the senior class at the finest hotel in the city, and we are building a finer one each year, so that it has been a little better one each year. Then the board members, present and past, and their wives, attend that reception and are introduced to the graduates; it is their coming out, so to speak, as women of the profession and not merely as pupils. This might have some relation to the subject under No. 10, because if you promote the social side of life in your training school, your nurses are going to be loyal to your institution, there is a relation between these two topics. Our board encouraged the graduates some years ago to form an alumni association and gave the money with which to start it, gave the money to start a sick benefit fund, and there will be a room fitted up by the Board and set aside exclusively for sick graduate nurses, for members of this Swedish Hospital Alumni Association, and that will be furnished just exactly as the association thinks best. That breeds loyalty, and those loyal graduates are going to go out and bring in more desirable applicants, and incidentally they are going to patronize your hospital and I do not know of any more effective means than a corps of graduate nurses to boom your hospital for you wherever they may be.

**Topic No. 8.—*The prevention of disease among pupil nurses.***

MISS ABREY: I do not think that superintendents in general have paid enough attention to the better feeding of their nurses and the observations of the laws of hygiene, and lastly, as one doctor says, continual washing of hands, and to see that these rules be insisted upon from the time the pupil enters the training school, as one doctor expressed it in a lecture to the nurses, "Water internally, externally and eternally."

MISS RIDDLE: Shall we not have done a great deal toward the prevention of disease among our pupils when we have improved the social side of training school life.

MISS PARSONS: I should like to say that we have found it very advantageous to have a doctor especially assigned for the duty of looking after the health of the pupil nurses and making a rigid rule that when a nurse feels in the least ill that she report at the office directly, and in that way serious illnesses are often prevented, I believe. We have had inoculations against typhoid with apparently very good results.

CHAIRMAN: That last sentence of Miss Parsons' naturally leads to the next question.

*Topic No. 5.—Should not the use of typhoid serum be made obligatory in training schools?*

CHAIRMAN: I should like to ask Miss Parsons if it is obligatory in the Massachusetts General Hospital?

MISS PARSONS: No, it is not. The nurses are all called together in groups as they come in in their probationer class and are told all about the serum, why it is desirable to have the inoculations, what the effect has been, and then it is left for them to decide and the majority of them elect to have the inoculations.

CHAIRMAN: I should like to hear from the superintendents of any hospitals in which inoculations are given.

MR. BORDEN: I do not think it would be possible to make the typhoid serum obligatory to the nurse unless you put it in the original contract when you offer the various inducements of the school to the nurse; I do not think either legally or morally it would be possible to oblige a nurse to submit to the treatment, unless she was told when she came into the hospital that that was one of the obligations she assumed.

DR. COOK: For nearly two years that has been the custom in our hospital and we have yet to have a nurse decline.

CHAIRMAN: I should like to have another standing vote to know in how many hospitals this practice is pursued. Will those superintendents in charge of hospitals where anti-typhoid vaccine is given as a common practice, kindly rise. Thirty hospitals, I take it.

*Topic No. 1.—How counteract the pauperizing effect of charity hospital services for people who can pay partially or entirely for their care?*

CHAIRMAN: We were unable to secure any one specially for that question, so it is open to any one who cares to answer it. If there is no one to answer that, we will go on to the next.

*Topic No. 4.—What is the most ethical means of advertising small hospitals?*

CHAIRMAN: Is Dr. Boyce in the audience? The question is open to any one.

MISS SARA A. BURNS: I think the best way to advertise small hospitals is to write to the doctor recommending the patient and tell him how his patient is doing, how he is getting along.

DR. BALL (Philadelphia): The best way to advertise the hospital would be to have on your staff the best men obtainable, to secure the best women in your training school that could be gotten and then get the best man that you can possibly afford to act as superintendent. I think that is the best way to advertise a hospital, for by doing so you will get efficient service and that is the advertising that is most effective.

CHAIRMAN: Let us hear from Texas.

DR. FRANKLIN (Dallas, Texas): I think Dr. Ball has given a good illustration of how we can best advertise our hospital, that is giving efficient service. Have a strong medical staff, then a strong nursing staff, then a good strong superintendent, the patient well satisfied and well cared for, and the hospital will be spoken of continuously and you will thereby reap the benefit.

DR. H. E. W. SIMON (Buffalo): I think the keynote has been sounded along that line when you say efficiency is the best advertisement. Then of course there are other ways of advertising hospitals, and that is when you are on a financial campaign, that is a good plan, but the most potent advertisement is efficiency.

MR. W. B. SOUDER (Philadelphia): Uniform courtesy in the office of a hospital. Everybody who comes in there, rich or poor, should receive the same courteous, kind treatment, they should be made to feel that they are not paupers, but that the hospital is interested in their welfare just the same as in the welfare of somebody who is paying. I always tell my office help that one of the first things I expect of them is to be courteous to everybody, to be kind in the treatment of everybody, to understand the needs of a hospital and to be able to answer questions promptly and accurately; and also the telephone operator, no matter how much she has to contend with, that when she speaks over the phone to anybody wanting information, to give it in a kind and courteous manner. Another thing I think, if people pay money for the hospital, if you write on the receipt, "With thanks," you make a good impression on people.

DR. HORNSBY (Michael Reese Hospital): The question, I believe, has been fairly well discussed. In our hospital with five hundred beds the question of efficiency is of prime importance. Courtesy is a secondary condition, I believe, but I think



that if people going to hospitals are properly treated, with a staff of physicians and surgeons that are expert in their lines, that the results for the hospital are only a question of time.

MR. BORDEN: I do not think anybody has answered the question as yet. I wish your friend Robertson were here to tell you what advertising is. Advertising is letting the general public know what you are doing, and there ought to be some ethical way for small, as well as large hospitals, letting the public know that they are doing good things for them. Let the public get the benefit and let the public pay for it. It is all right to make a good reputation, but good reputation is not advertising in the sense of the word.

DR. BALL: Personally I think it is just as unethical for a hospital to go out and blow its own horn, say, "We treat patients better than any other hospital," as it is for a physician to do the same thing.

MR. OLSON: This is the last time I am going to speak tonight. I used to be something of an advertising expert and in connection with hospitals I found this, that indirectly your most effective advertising departments are the kitchen and the laundry, and then after that there should be consistency. Your printed matter should look as clean as though it came from the laundry and as delicious as though it came from the kitchen. You understand what I mean. Now your people will talk about the good food and the beautiful trays and the fine linen long after they have forgotten their ills. It is the appearance of everything, and then if you publish your reports in such form that it looks as clean as the linen and just as delicious as the food, your advertising is as effective as anything that goes out.

DR. FOWLER: It seems to me the question of counteracting the pauperizing effect of charity hospital service, and so forth, might be changed to read in this way, how to prevent people who are able to pay from imposing upon charity. I think that is a necessity and a very common thing to avoid in charity hospitals. It has been so in my own experience that certainly a hospital that has a reputation of being very well endowed, there are many people who feel that it is perfectly proper and legitimate to get free treatment in an institution which is well supported, and it is surprising how many people who are able to pay seem to lack the moral sense in regard to that part. It has been my experience that people who are induced to pay ever so little, appreciate more highly what is done for them. The complaints that come mostly are from people who have obtained something for nothing and endeavor to belittle what they get to square their consciences and their feelings in regard to the matter.

MR. SOUDER: I can speak of a hospital from the other side. I speak for one of the poor struggling hospitals and we find the same trouble as the gentleman from Tennessee, people taking advantage. I think a great deal of it is owing to lack

of knowledge and education in regard to hospitals. A great many people have the idea that the hospital receives state pay. In Pennsylvania we are supposed to get one dollar a day for all public patients that cannot afford to pay; but the people there seem to think that because you receive a small endowment from the state, that you have got to treat them for nothing. Some time ago a gentleman walked in suffering from some trouble, and after he had been treated I rendered him a bill and he politely told me that the State of Pennsylvania apaid for his treatment. I think people should be educated up to understand that hospitals are not supposed to treat people who can afford to pay, for nothing. By a system of education I think to a great extent the pauperizing effect would be done away with.

*Topic No. 9.—The relation of the hospital to the organized charities of the city.*

CHAIRMAN: Has anyone anything to say on this subject? It is now nine-thirty. We have had a very long day. If anyone has any subject that he would like to bring up for the good of the conference, we would like to hear from him. There is one question I should like to ask and that is this, the program committee gave this whole day to the small hospitals. This is the first occasion on which I think the smaller hospitals have had a session to themselves, and I am convinced that it has been an unqualified success, and I think it would be well to indicate to the officers that come on next year as to whether you would like a whole day next year or two days. I heard one man say he would like four days. Just a little indication to the program committee as to how much time you would like. I would like to hear from some members in regard to that.

DR. BALL: I was very much disappointed when Question No. 7 came up to find that very few here had anything to say about it. Now the answer to that question is really one of the things I came here for. I want to hear from some women who have had experience in hospitals for so many years, I would like their opinion as to how far you can go in a hospital in allowing the resident physician to associate with the nurses. Our hospital is situated about, I should say, a quarter of a mile from the nurses' home, and it is necessary for the nurses to walk that long distance at night and quite frequently it might happen that one of the resident physicians would meet a nurse and walk in with her. It was very strongly impressed upon me one night when I was coming along in my machine and found three nurses struggling along the dark road and I brought them in. If I had been a resident physician, I wonder if that had been considered a breach of the rules. I should like to know what the practice is; how far they permit the resident physician to associate with the nurses.

CHAIRMAN: This topic was discussed last year, or the year before, so that anyone who wishes to find out what was said before can look it up. Although it has been up on a previous occasion, that does not bar out the question tonight. I think

the subject generally is one of the greatest importance. In the old country universities, Oxford and Cambridge, a great deal of the time of the students is spent in a social way, talking over all sorts of subjects. Coming to our own Association here tonight, and our meetings here four or five days, I am sure many of you will agree with me that a great deal of benefit is derived from meeting in groups of three or four at the tables in the dining room, or in lobbies or wherever we are staying and informally discussing many questions. It seems to me that the nurses who go on duty at seven o'clock in the morning and work more or less constantly until seven o'clock in the evening, surely that is too much and I think without doubt that there should be an endeavor on the part of hospital authorities to introduce into training school life very much more social life than the nurses have at present. It is not time lost at all, by any manner of means. Miss Riddle has pointed out that their health would be much better as a result and when examinations came we would find they would do better than at present.

DR. KAVANAGH: I should like to ask a question: Is there much complaint because of lack of social life in hospitals on the part of nurses? I think that the girls when they get off duty are about the happiest crowd you can see, simply not because of what they are doing, but because they have gotten together themselves. Of course in our hospitals we have these various socials that others speak of, we celebrate every function that comes along that we possibly can. There is trouble with the staff a little bit, if the staff is too conspicuous. In these specially arranged socials they are not apt to get through. You cannot find two or three of them together but what they want to arrange the program themselves, then it keeps the superintendent busy to see that the sociability closes down at the proper time. The fact is, that I have never heard any great complaint as to lack of social life. Take 50 or 60 or 70 girls together and off duty, most of them, they are going to have a good social time, and they have it. I think that we raise a question that really does not cut very much figure and I am seriously asking if there is a question.

MR. M. DAVIS: I believe it is not so much for the fun as it is have we any right to take these young women out of their home and offer them their training for three years during the formative period of their life and not direct them to any better thing. We give them much along one line, they come to us for that, but wouldn't it be better and make them more symmetrical, if you could give them a little direction, possibly along the lines of better music, better lectures and some of the better things of life, and when they go out they will not be quite so one-sided, they will be more symmetrical because of our opportunity to direct their life. So many of them are still in the formative period of life, and I think our responsibility does not cease, we do not give them all that we may just along medical lines. I think that we ought to work and carry on a little bit of home life for them as well as the rest of our ideals.



DR. KAVANAGH: That is a capital speech and full of suggestions. That is not, however, what some have meant by the question. It is much better than perhaps what the question suggests, and if the question means that, then many of us are trying to do that very thing. For example, we have in our chapel frequently through the year concerts, when we bring in the very best talent that we can find, we get the very best. We have the illustrated lectures of a popular order, and only the other day the supervisor of nurses at the house and myself spent quite a time together planning as to what lectures and entertainments entirely apart, as we put it, from hospital life and hospital work, we could plan for the coming fall and winter. I would not be surprised if many of our hospitals are doing that sort of thing. But that was not I thought our idea, I thought something different was meant in connection with sociability.

CHAIRMAN: Referring to Question No. 9, Mrs. Lewis has a word to say, and we will be delighted to hear from her.

MRS. LEWIS: Our American Association is very strongly interested in what the small cities throughout the country are doing in co-operation with the associated charities and small hospitals. For the last two or three years I myself have been experimenting with them in the small city work and we have found that the very foundation of good work among dependents of the city is to get the co-operation of the hospital of a small city and the associated charities work of that city. I should like to say in illustration of one or two things that we are trying to do in Newburyport, Mass., in that way. We are making our associated charities the social service department of a hospital. This is not only along the lines of the good of the patient but for the administrative possibilities within the hospital. You brought up the question a few moments ago about pauperizing people. We have established this little system which we are, however, working out gradually with the hospitals. All patients who feel that they cannot meet their expenses at the hospital, through the associated charities, that family is investigated and reports sent to the hospital as to whether they are able to pay their bills or not. If we feel that they are, we report that to the board, or to the superintendent and they act accordingly. If we find that they are not, or if we find a family in need of hospital care we report that and ask for co-operation. So we do feel that, especially in the small city and with the small hospital, the charity organization department should take the place of the social service department of the large city hospital, and we feel that our charity organization workers should have hospital social service training, and while that is comparatively a new thing, I do believe that many of our best workers are going to give up their work for a time, if necessary, in order to take training along hospital lines and numbers of our secretaries in our social service schools are taking the work here at the Massachusetts General Hospital, and so I feel personally, as representing our American Association, like putting in a strong plea for the hospital to co-operate with the charitable work of the town.

CHAIRMAN: I should like to have an expression of opinion as to the amount of time you would suggest to the Committee on Arrangements next year to be given to small hospitals. Mr. Haworth I think is mainly responsible for the introduction of this subject.

MR. HAWORTH: I want to say, last year we asked for two days and we are fortunate, I believe, in getting one day. I think next year we ought to have two days. This session has been so satisfactory that everyone is in favor of it, at least everyone I talked with is very much in favor. I should like to have two days next year for our small hospitals.

CHAIRMAN: Those that are in favor of asking the Program Committee to devote two days of next year's program to the section of the small hospitals, kindly say aye. It is carried. I thank you all for the attendance and also for the interest in the discussions.

#### **THURSDAY, AUGUST 28—MORNING SESSION.**

The meeting was called to order at 10 a.m., President Washburn in the chair.

## REPORT OF MEMBERSHIP COMMITTEE.

To the American Hospital Association:

Your Committee on Membership begs to report that 176 applications for membership have been received; 173 of which appear to be eligible for membership to the Association—118 of these 173 are Superintendents of hospitals; 24 Trustees, 16 Assistant Superintendents and 15 members of charitable organizations.

According to states the applicants are divided as follows: Massachusetts, 34; Pennsylvania, 19; New York, 15; Canada, 14; Ohio, 14; Illinois, 13; Michigan, 9; New Jersey, 8; Minnesota, 5; Kansas, 5; California, 3; Georgia, 3; Kentucky, 3; Maryland, 3, and Missouri, 3; Connecticut, Iowa, Maine, Oklahoma, South Carolina, Tennessee, Vermont and Washington, each 2; Alabama, Alaska, Louisiana, New Hampshire, Philippine Islands, South Africa and Texas, each one.

According to the Secretary's list there have been some 28 names deleted from the membership, as a result mainly of members dying or relinquishing hospital work.

Your Committee feels bound to specially commend the efforts of one of its members, Dr. James C. Johnston, of McAlester Hospital, Oklahoma, who at his own expense sent circulars to the superintendents of hospitals in his own and adjoining states, calling attention to the value of membership in the Association, and strongly urging his fellow workers to unite with the organization.

Your Committee recommends the reception of the new applicants as members of the Association.

Respectfully submitted,

J. N. E. BROWN,

For Committee.

PRESIDENT: You have heard the report; what is your pleasure? The report will be accepted and placed on file.

I have a letter from Miss Keith, member of the Nominating Committee, saying that she is unable to be present, and I will substitute Mr. Reuben O'Brien, of New York.

The Treasurer reports that the Auditing Committee has the books, so he cannot make a report at the present moment. I will ask for a report of the committee appointed to make recommendations concerning the suggestions made by the President and I will ask Dr. Fowler to read the report.



## REPORT OF COMMITTEE TO CONSIDER PRESIDENT'S ADDRESS.

To the Members of the American Hospital Association  
in Convention Assembled at Copley-Plaza Hotel,  
Boston, Massachusetts:

Your Committee appointed to take under consideration President Washburn's address and his recommendations, begs leave to report as follows:

1. We strongly commend the general tenor of the address and recognize it to be a very able contribution to the welfare and improvement of the American Hospital Association.

2. We heartily endorse the recommendation that the Association has become too large, and its personnel too complex, to work to the best advantage in a single section, and we recommend that the Association at this conference should authorize the next President and Executive Committee to arrange to meet in as many sections as they may deem expedient.

3. We recommend that his suggestion that the Association enlarge its membership by admitting hospital physicians, surgeons, pathologists and superintendents of nurses as associate members be adopted.

4. We unanimously agree with Dr. Washburn, that the ideal medical and surgical hospital work would be best attained by paid chiefs of staff, with continuous service; and whilst this would apply to many of our larger hospitals, we do not think it practical to recommend its application to all.

Very respectfully submitted,

J. W. FOWLER, Chairman.  
DR. WINFORD SMITH,  
JOHN M. PETERS.

Section 3 of Article 3 of the Constitution be amended by adding after the word "charities" in the fifth line, the words "hospital physicians, surgeons, pathologists and superintendents of nurses."

## DISCUSSION.

DR. FOWLER: I move its adoption.

PRESIDENT: It has been moved and seconded that the report just read be adopted. Inasmuch as, Dr. Fowler, it would mean changes in our by-laws, it will have to lie over.

DR. FOWLER: I would give this notice, Mr. Chairman. I shall move at the next session that the Constitution be changed, Section 3, Article 3 be amended by adding after the word "Charities" in the fifth line, the words "Hospital physicians, surgeons, pathologists and superintendents of nurses." I shall move that at the next session.

PRESIDENT: You have heard the notice of the proposed change in the Constitution that will come to your attention for a vote at the next session of this convention. The motion before the house is the acceptance or the adoption of the report. Is there any further discussion? Those in favor will please say aye, opposed, no. It is carried.

If it is agreeable we will now have the report of the Committee to Memorialize Congress to place Hospital Instruments on the Free List. Dr. Clover is absent and the next member of the Committee, Dr. Kavanagh, will read the report.

**REPORT OF COMMITTEE TO MEMORIALIZE  
CONGRESS TO PLACE HOSPITAL  
INSTRUMENTS ON THE  
FREE LIST.**

Frederic A. Washburn, M.D., President, American Hospital Association, Massachusetts General Hospital, Boston, Mass.:

Mr. President:

As Chairman of the Committee to memorialize Congress to Place Hospital Instruments on the Free List, I beg to report that I prepared for the Committee a brief on the subject (a copy of which is herewith submitted with a portion of this report) and submitted to the Honorable Committee on Ways and Means of the House of Representatives. I also appeared before the Committee personally on January 31st, 1913, and made a plea to permit hospitals to import free of duty medical and surgical instruments, appliances, apparatus (including Roentgen Ray plates), utensils, and chemical and pharmaceutical preparations.

The opposition on the part of surgical instrument manufacturers and others to our petition was intense. The statements made by some of the gentlemen in opposition were misleading, while others were erroneous. In contradiction to these statements I prepared and filed with the Committee a brief reply.

The testimony on the subject of surgical instruments will be found on pages 5930-5965, inclusive, of the Tariff Schedules and Hearings before the Committee on Ways and Means, House of Representatives, on the Free List, Miscellaneous and Administrative, January 31st and February 1st, 1913.

Some time after the hearing and upon learning that it was not thought possible to grant our petition to change Paragraph 650 in such wise that hospitals should be included among institutions permitted to import their apparatus duty free, I urged the Committee on Ways and Means to place surgical instruments and appliances in the free list without special



regard to hospitals, or if this could not be done, to diminish the rates of tariff as much as possible. I was actuated to this by understanding that it was considered by the Committee on Ways and Means to be inexpedient to grant special privileges to hospitals in the way of remitting duty on their importations for the following reasons :

1. Because it would make the operation of the law exceedingly difficult, and

2. Because there was a strong feeling that some hospitals would abuse the privilege.

The Bill as introduced by the Chairman of the Committee on Ways and Means in the House of Representatives on April 21st, 1913, places the average duty on hospital instruments at 25 per centum, as against 40-45 per centum ad valorem under the Tariff Bill of 1909.

When the Finance Committee of the Senate was in Session, I appealed to the Chairman of such Committee again, urging the remission of duties on surgical instruments and implements. In the report of the Senate Act of July, 1913, with amendments, the average duty on surgical instruments is reduced apparently to 20 per centum ad valorem. I say "apparently" because the tariff duties are not designed for surgical instruments as such, but are provided for to some degree under Schedule N as "sundries" and in other cases are provided for specifically naming the articles under Schedule C, as "Metals." It is possible that a strict interpretation as to under what schedules certain instruments come will not be made until instruments are imported. I believe, however, we can feel assured that with the exception of scissors the duty on instruments will be reduced from between 40 and 45 per centum to 20 per centum ad valorem. On scissors the provision is for a levy of 30 per centum ad valorem.

It is, in my opinion, not advisable to make a repeated effort to obtain special exemption for hospitals, but I would recommend that a committee be appointed to endeavor to obtain further reduction of duties on surgical implements and apparatus without reference to hospitals and with a view to getting these articles placed eventually on the free list.

Respectfully submitted,

GEO. F. CLOVER, Chairman.

*To the Honorable Members of the Committee on Ways and Means, House of Representatives.*

We, the Undersigned, a Committee appointed by the American Hospital Association, founded to promote the economy and efficiency in hospital management, respectfully petition and recommend that paragraph 650 of the present Tariff Act which now reads:

“Philosophical and scientific apparatus, utensils, instruments and preparations, including bottles and boxes containing the same, specially imported in good faith for the use and by order of any society or institution incorporated or established solely for religious, philosophical, educational, scientific, or literary purposes, or for the encouragement of the fine arts, or for the use and by order of any college, academy, school, or seminary of learning in the United States, or any State or public library, and not for sale, subject to such regulations as the Secretary of the Treasury shall prescribe,”

be changed so as to read:

“Philosophical and scientific apparatus, utensils, instruments, and preparations, including bottles and boxes containing the same, specially imported in good faith for the use and by order of any society or institution incorporated or established solely for religious, philosophical, educational, scientific, or literary purposes, or for the encouragement of the fine arts, or for the use or by order of any college, academy, school or seminary of learning in the United States, or any State or public library, and not for sale, and all medical and surgical instruments, appliances, apparatus (including Roentgen Ray plates), utensils, and chemical and pharmaceutical preparations, including bottles and boxes containing the same, specially imported in good faith for the use and by order of any hospital, asylum, or other institution rendering medical or surgical aid to the public or any portion thereof free of charge, in which instruction in medicine and nursing is given, and whose expenses are borne wholly or in part by public funds, private subscription, or endowments, such articles and preparations, to remain the permanent property of such

hospital, asylum or other institution, and not for sale, subject to such regulations as the Secretary of the Treasury shall prescribe."

### *American Hospital Association.*

The American Hospital Association is composed of hospital trustees, managers, contributors and officers of charitable institutions. The Association aims to promote economy and efficiency in hospital management, to educate the people regarding hospital needs, to disseminate information regarding every phase of hospital work, to assist those who are carrying hospital burdens, and in every possible way to improve the care of the sick.

There are about 6,000 hospitals in the United States, including sanitariums and private hospitals. Of these over 3,000 hospitals may be rated as public or semi-public; that is, that were founded and are maintained as charitable institutions supported by municipalities, counties, or by endowment and private subscription. These hospitals are both eleemosynary and educational in their work. Few of them have sufficient income to meet their expenses, and the vast majority are forced to meet an annual deficit by private or public subscription. Any present saving of expense is used and any future saving of expense will be used for increase or betterment of work, resulting in a larger and more thorough care of the sick, and especially of the sick poor. These hospitals are now caring for over 3,000,000 bed patients, representing 60,000,000 days of hospital treatment, and many times that number of ambulatory patients annually.

### *Importation of Surgical Instruments.*

As representatives of hospitals thus maintained in whole or in part by public and private subscription or endowments, wherein surgical and medical attention is given free of charge, to the dependent poor, we wish particularly to emphasize that many of the important surgical instruments and invaluable medicinal preparations, which are the result of careful and painstaking medical study and research, *must be imported from abroad*. Approximately 40% of the medicinal prepar-



ations are at present imported from England, Germany and Austria, and over 80% of the surgical and scientific appliances also are imported.

The European duty on surgical instruments is very low compared with ours. Italy exacts a duty of 30 lire per 100 kilograms, or about .026 cents per pound; Switzerland's tariff is 10.6.6 per cwt., or about one and one-half cents per pound. Canada and Mexico admit such instruments duty free.

### *Educational Importance of Hospitals.*

As we understand paragraph 650, only schools of learning, universities, colleges and other educational and scientific institutions are permitted to import free of duty such instruments as are needed in their places of teaching. Many of the schools and colleges of this country have rich endowments, besides receiving large tuition fees from the pupils taught.

Yet, although hospitals are doing an educational work, the value of which to the country at large, is hardly surpassed by institutions of pure learning; the same privileges with regard to release from import charges is not accorded them. It is not alone in the medical college, but in the hospital that practical understanding of the nature of diseases and their cure is acquired. Teaching in the college is theoretical. In the hospital it is practical. The best medical colleges are beginning to assume the position that they will not graduate medical students who have not had some hospital experience. But the hospitals, despite their wide educational scope are often beset with financial difficulties, since they have fewer bequests, no income from tuition fees for teaching internes and nurses. Practically all the public or semi-public hospitals give instruction to internes and nurses and in most cases pay out a small stipend to these students for the services they may render, with room, board and laundry work while they are in training. This is a constant drain on the limited resources of an institution dependent to a large extent upon public charity for a successful financial management. Medicines, often costly, are given charity patients both in the hospital proper and the dispensary or out-patient department. While schools are differentiated in paragraph 650, many hos-

pitals are connected with these same schools, and while no corporate connection is apparent, they receive students into their wards for special training, as part of the school course, for practical experience in medicine and surgery cannot be obtained from text books.

### *Laboratory Work.*

The best hospitals today have extensive pathological, bacteriological, chemical and Roentgenological laboratories attached, where work of a highly specialized character is done, both in educational, research and diagnostic channels. In these laboratories apparatus of expensive character are used that are not made in the United States.

### *Duty Should be Free.*

As to taxation for revenue, the loss to the Government in granting our petition to admit these articles free of duty would be small, while the gain to the hospitals, and the consequent increase of hospital facilities to the poor, will be great. Surgical instruments pay a duty according to material, which average about 40% *ad valorem*. Moreover, the government cannot wish to derive its revenue from institutions if the payment of such revenue interferes with the increase of the care of the dependent sick poor.

Respectfully submitted,

AMERICAN HOSPITAL ASSOCIATION.

Committee to Memorialize Congress to Place Hospital Instruments, etc., on the Free List:

REV. G. F. CLOVER, Chairman.

REV. A. S. KAVANAGH, D.D.

DR. J. N. E. BROWN.

DR. W. L. BABCOCK.

DR. W. H. SMITH.

### DISCUSSION.

PRESIDENT: It has been moved and seconded that the report of the Committee to Memorialize Congress to Place Hospital Instruments on the Free List, be accepted. Those in favor say aye; opposed, no. It is carried unanimously.

Is it your desire to take any action on the recommendation of Mr. Clover that a committee be appointed? I should think that if this committee is continued that will cover it all.

# **TREASURER'S REPORT FOR YEAR ENDING AUGUST 27, 1913.**

## **RECEIPTS.**

Membership and dues .....	\$2,815 50
Commercial exhibit .....	529 24
Annual Report sales .....	20 00
Cash balance, Sept. 21, 1912 .....	1,693 35
	<hr/>
	\$5,058 09

## **DISBURSEMENTS.**

Clinical Services .....	\$ 567 00
Postage .....	350 00
Printing .....	1,380 52
Exchange on checks .....	8 05
Detroit Convention .....	196 00
Expense .....	4 62
Expense of committees .....	161 80
Non-commercial exhibit .....	271 63
Sundries .....	50
Cash balance .....	2,117 97
	<hr/>
	\$5,058 09

**ASA BACON, Treasurer.**

MR. BACON: The other increase is due to the exhibit of this year. All the money for the rented space is turned over to the Treasurer and of course all the bills will be turned in, so that \$529 shown as receipts will partly be wiped out by the bills when they come in, so that it will still leave a larger cash balance by far than we had last year at this time.

PRESIDENT: You have heard the report of the Treasurer; what is your pleasure?

On motion, the report of the Treasurer was accepted.



## AUDITING COMMITTEE'S REPORT.

To the American Hospital Association:

We hereby certify that we have examined the books and vouchers of the Treasurer of the American Hospital Association from Sept. 24, 1912, to Sept. 27, 1913, and beg to report as follows:

Balance on hand, Sept. 24th, 1912 .....	\$1,693 35
Receipts .....	3,364 74
	<hr/>
	\$5,058 09
Disbursements .....	2,940 12
	<hr/>
In hands of Treasurer .....	\$2,117 97

Respectfully submitted,

JAMES R. CODDINGTON,  
REUBEN O'BRIEN,  
H. P. FROST,

*Auditing Committee.*

### DISCUSSION.

MR. CODDINGTON: It has been the custom of the Treasurer, as we understand, to take his accounts down to any date during the meeting when the Auditing Committee desires to have the report. We feel that it would be very much better if this were discontinued and the report made from meeting to meeting and then would include the year, instead of running in the two years together. As far as these unreceipted vouchers are concerned, the Treasurer has been away for a number of weeks and is ending up his vacation here and has ordered his papers sent to him. The majority of these vouchers are probably awaiting him at his home and might have been paid by check, for which he has a cancelled check he feels sure. We, having absolute confidence in our Treasurer, I would suggest that in accepting this report or previous to accepting it, that the remarks and the tabulation of these unreceipted vouchers be stricken from the report, so far as the publication of it, at least, is concerned. I do not think it would look very well for us to send out our annual report with this amount paid and no voucher showing for it.

PRESIDENT: You have heard the report of the Auditing Committee with the suggestion; what is your pleasure?

On motion, the report of the Auditing Committee was accepted.

PRESIDENT: I take it that Mr. Baker is willing to accept that suggestions about ending the accounts.

MR. BACON: Yes.

PRESIDENT: If it is the pleasure of the Convention, we will now consider the proposed change in the By-laws. Day before yesterday this motion was submitted, that we strike from Article IV., Section 1, the third phrase, reading "The President shall appoint a Committee on Nomination of Officers of three members," and Section 3, Article IV., which reads "The Committee on Nomination shall nominate to the Convention the names of candidates for President, three Vice-Presidents, Secretary and Treasurer. The action of this Committee is at all times subject to the approval of the Convention. The matter is before you for discussion.

DR. W. L. BABCOCK (Detroit, Mich.): I am very glad that this subject has been opened up for discussion. As chairman of the Nominating Committee I have had one or two members during the past year make the suggestion to me that some move be made here at this Convention for the nomination of officers from the floor. In view of the presentation of this resolution the Nominating Committee has not had a meeting or made nominations for officers. I think the Convention should carefully analyze the pros and cons of this matter. Those who are in favor of it may be able to give the pros. I can not. On the other side, would it not reflect upon the dignity of an humanitarian or scientific association, to attempt to nominate officers from the floor? In other words, we would be injecting politics into our work. While a few, if any, members or no member of the Association would in any probability seek the office, there are those who might have a coterie of friends who would be electioneering or working for them throughout the meeting. It would be a matter of confusion and distaste, to say the least. Then, again, we have present at each Convention from fifty to seventy-five new members. The new members, as a rule, know nothing about eligible candidates for office. Usually the members of the Nominating Committee—we will except this year's Committee—may be supposed to know something about the qualifications of the candidates proposed. The present by-laws provide that nominations for opposing candidates can be made from the floor. The election is open to the Convention, which is not obliged to accept the report of the Nominating Committee. The report of the Committee on Time and Place has not been accepted on several occasions and other cities have been nominated from the floor. I think it would be rather a backward step and would savor of labor unions and social clubs if we attempted that sort of nomination. The Nominating Committee might bring in two tickets and leave it for the Convention to decide. It is a matter for the members present to decide, but it strikes me that we should retain a dignified method for nominating our officers and keep up the continuity of our work by that means.

DR. KAVANAGH: Having brought this matter forward I ought to make a statement or two, perhaps, in regard to it. In the first place, I have heard during the year the same sort of request, the same sort of rumors and criticisms that Dr. Babcock has referred to—criticism of the method rather than the men elected. If Dr. Babcock has been around here during the meeting and has not been approached by anybody with regard to candidates, then it is simply because he has left the room, and what is true this year has been true every year. We are not exactly a Simon-pure body, free from the infirmities of the flesh any more than other organizations. The fact is that wherever there is a President or Vice-President to be elected and there are 300 or 400 people involved, it is contrary to human nature not to talk a little about it during the meetings until the thing actually happens, and I do not think we are any the worse or any the better because it happens to be the case. Now as to nominating from the floor, that is not in the motion at all. It is not in the amendment, Dr. Babcock has read it into the amendment himself because, I suppose, he thinks that that method is necessary, as a matter of fact that method is unnecessary. I am not so particular whether we adopt the amendment or not. A very simple method would be this: an informal ballot could be taken for President and those having the highest votes should be the candidates, no nominating speeches whatever being made. Every individual member of the Society would be recognized by this method. Now suppose there are fifty or one hundred that do not know anything about the business, then they need not vote. The fact is that the one hundred, or one hundred and fifty, more or less, who write a name on the ballot will do so because they have some conviction about it, and the conviction of that man or that woman who may not be in the inner circle may be just as good and just as weighty as though they sat on the front seat. Now this matter has been in the air and we have discussed it quietly, year after year. Even this splendid journal that has been launched during the past two weeks, on the staff of which are found the most distinguished names perhaps in this Association, editorially called attention to the fact that it would be a move in the right direction. He says it would be progress. You say it is progress in the wrong direction. I should like to know who knows more about this thing, the distinguished editor of the Modern Hospital or the chairman of this Committee. Now I am not particular how this thing goes. I will tell you frankly I am not a candidate, never will be, would not know what to do with the thing if I got it, but I do not think Dr. Babcock is a very good judge of this matter, as he was elected by this system. He does not want to go back on it.

DR. HURD: I would suggest that this is a personal talk.

DR. KAVANAGH: This is a very friendly talk. I am simply saying that a man having been elected under this system ought to keep silent or defend it, but I want you to understand that while this thing has been going on year after year and good men have been elected, where has there been any recognition of the elements that make up the majority here, why have we not



had a woman presented for the presidency of this Society? They have a woman in Chicago at the head of the school system, the most efficient they have ever had; we have women here that are capable of being at the head of this institution. We have laymen here, laymen that have been doing the practical work of the Association and nine-tenths of the work of the hospitals is of a practical business-like nature, but since Mr. Ludlam was President we have had no layman for President of the Association. This Committee arrangement may be of a very high order, it may be splendid, but I want to tell you this, that if this body were choosing for itself, it would not pass by the laymen for eight or ten years in succession. We should have a more democratic policy and everybody should have an opportunity to vote for the candidate that he desires, but as to the matter of log-rolling that will occur no matter what your system of election happens to be.

PRESIDENT: Any further discussion? I will ask anyone who discusses this subject to endeavor to avoid all personalities, or any appeal to sectional or partisan feeling. It is very much out of place in this body. (Applause.)

DR. HURD: It is a matter of perfect indifference to me what method you select for choosing the officers of the Association. My own idea has been that an official position in this Association meant service, meant work. Personally I can say that I never desired to be President, it was with the greatest reluctance that I accepted, and had I known that I should receive my position through log-rolling or intriguing of an inner circle, if I had known about it I would have absolutely declined. I have always believed in an association of this kind no one should seek an office and no one should avoid an office. At the same time I do not believe that anyone has been neglected in the matter. The only object of the Nominating Committee heretofore I am sure has been to get the best men for the place, and I personally am not willing to vote in favor of this change because I see no reason for it.

DR. FISHER: I certainly hope that the motion is not going to prevail to do away with the Nominating Committee, for I feel, as has already been intimated by some one who has spoken, that there will be a Committee, self-appointed, if you please, of individuals or a group, perfectly natural, as some one has said, we are not perfect yet, there will be a Committee. Now why not have a Committee that we all know about, a Nominating Committee appointed by the President or by the Conference, if you please, but why not have a Committee that we know about and to whom we can send in our ideas of who shall be President. I am sure that there is no Nominating Committee but what would be mighty glad to have names sent in to them, and those that are accompanied by large backing will be welcome to a Nominating Committee. There is bound to be a Committee, say what you please. It will be a self-appointed one if it is not appointed by the President. There will be cliques and gatherings of people who will do the work and why not continue our policy? The

work of the Nominating Committee has always been successful I think, and I believe it has been above board. I have not heard anything until today about inner circles. I still believe in a Nominating Committee that we know about, that we can get at and that you can present names to. I think that we are too large an organization now to use the open floor method. The success of that often depends upon the person who gets up and has the largest voice, or the greatest flow of language that does not always carry with it wisdom. I still go back to the Nominating Committee and hope the Nominating Committee ideal will be preserved.

DR. GOLDWATER: I ask that the resolution be read before we proceed to vote.

PRESIDENT: This motion was presented by Dr. Kavanagh. (Reads.)

DR. GOLDWATER: Do I understand the resolution does not specify the number of members to be presented for the presidency?

PRESIDENT: It does not specify. The Committee on Nominations shall nominate to the Convention the names of candidates for President. The Committee can recommend as many as they see fit. Are you ready for the vote?

A MEMBER: It seems to me that the by-laws as they now stand give sufficient latitude. Let the Committee on Nominations choose the three highest names that are suggested to them for President, and the six highest names that are suggested for Vice-President, or the five highest, as has been suggested, and with a system of balloting we can easily select our candidates. There is no necessity for changing the law.

MISS AIKENS: There is a clause in the By-laws that states that the Committee shall be appointed by the President unless otherwise provision is made, and it seems to me that this Association might very wisely make a condition that the Nominating Committee shall be nominated from the floor and that will give almost everybody a chance to say something and require no change in the By-laws whatever.

The question was called for.

DR. KAVANAGH: A question of privilege. I want to say in explanation, I do not want to take all the credit for this amendment, I came in with a different one in my pocket. sat down by the chairman of the Committee who remarked to me: "That motion is too long, I think we can present one that is shorter," and the one that was handed up was drawn up by the chairman of this Committee, Dr. Babcock, and he should have full credit for drafting the motion that we are acting on now.

PRESIDENT: Are you ready for the motion? It takes a two-thirds vote for changing the By-laws. Those in favor of elim-

inating the section please rise. Only active members can vote. Those opposed will rise. It is unanimously rejected.

DR. BABCOCK: I should like to request that members of the Association who have candidates for any office suggest the names to the Nominating Committee. The members are Mr. O'Brien, Mr. Kenny and myself. I would ask that you do this directly after the close of this meeting if possible, as we should like to bring in a report this afternoon for the consideration of the Convention.

MR. OLSON: Would it not be well to instruct the Committee to submit at least three names for the office of President?

PRESIDENT: The Committee is left to its own discretion under the By-laws. If it is agreeable to the Convention, we will ask the Nominating Committee and the Committee on Time and Place of Next Meeting to report at 2.30 o'clock this afternoon, that will be the first thing at the afternoon session. I will give notice so that you may all be present. We will now come to the business of the morning.



## PRESENT STATUS AND PROBLEMS OF OUT-PATIENT WORK.

BY MICHAEL M. DAVIS, JR., Ph.D.,

Director of the Boston Dispensary.

Report of Committee on Out-Patient Service, American Hospital Association.

The dispensaries and out-patient departments of the hospitals of the United States are growing yearly in importance as a part of medical service to the public. The Federal Census of 1910 reports the existence of 574 dispensaries and out-patient departments treating 2,349,000 patients during the year. Only six years previously, when in 1904 a special report of benevolent institutions was issued by the Census Office, there were but 156 of these institutions, and the number of patients was only 1,611,000. Thus in six years the number of dispensaries and out-patient departments increased near four-fold. The number of patients increased of course much less rapidly, as the newer institutions are largely for tuberculosis, and are small in size; yet, even so, the increase in patients treated is over 50%.

### STATISTICS OF OUT-PATIENT WORK.

As a matter of statistics the figures reported by the Census Bureau for 1910 are undoubtedly too small. There has been considerable confusion, in the reports made to the Census Bureau, between the number of patients treated and the visits paid by these patients and also—surprising as it may seem—between out-patients and bed-patients. The officials of the Census Bureau tell me in correspondence that they have done their best to get the hospitals to report bed-patients *as* bed-patients and out-patients *as* out-patients, and not to swell the number of hospital cases by putting out-patients within that total. In the present state of out-patient statistics, it is perhaps beyond sane expectation to think that when a hospital does not accurately distinguish in its report between bed-patients and out-

patients, it will give attention to such a relatively subtle matter as to discriminate between patients treated in the dispensary and visits paid by these patients. But the millennium will come sometime!

Meanwhile, a comparison made with reports of local authorities in certain states and the Census figures show the Census figures to be below the truth. In Massachusetts the State Board of Charity receives reports from all hospitals and dispensaries and the same practice exists in New York. The Massachusetts report indicates that the Census figures for patients treated is about 20% too low; and the New York figures are 15% too low. It is probable that 2,750,000 to 3,000,000 individual out-patients were treated during 1910 and surely 3,000,000 are annually treated in this country at the present day.

The printed report of the Census Office, giving the 1910 figures, has not yet appeared, and I am indebted to the officials of the Census Bureau for the advance summary which they have kindly furnished me and for helpful correspondence concerning the method by which the statistics were gathered.

Out-patient work is not evenly distributed over the country. In 1910, just two-thirds of all the dispensaries and out-patient departments were in New York, New Jersey, Pennsylvania or in the six New England states; 60% were in New York and Pennsylvania alone. In the six years between 1904 and 1910 the number in New York trebled; in Massachusetts, doubled; in Maryland, doubled; in Illinois, a little more than doubled; in Ohio nearly trebled; in Missouri more than trebled; in the District of Columbia more than quadrupled; and in Pennsylvania the number of dispensaries increased twelve times. This remarkable growth in the number of institutions is in a considerable degree accounted for by the use of the dispensary in the national anti-tuberculosis campaign. Nearly all of the increase in Pennsylvania and fully half of the increase in the United States as a whole is due to this factor. The establishment of dispensaries has thus far been chiefly in the large cities, but there are indications that this will not remain the case. Tuberculosis dispensaries are established in every county in Pennsyl-

vania; and, under a new law, are to be established over all the state of Massachusetts. With the exception of these tuberculosis dispensaries, the typical out-patient work of course is to be found in the larger cities.

This increase in dispensary work places before the medical profession and hospital authorities certain serious problems, of which competition with private practice is one. These problems must be faced and solved; but the ultimate test on which the general public, which supports all the institutions, will base its contributions or its tax levies, will be the service of these institutions to public health. We must not reach decision upon any of the important problems of dispensary service with any narrower vision of it than as a part of the public health movement.

#### LACK OF ATTENTION TO OUT-PATIENT DEPARTMENT.

In view of the remarkable development of out-patient service, it is all the more noteworthy that most hospitals which conduct out-patient departments have paid so little attention to them. The dispensary might be described as the dark horse of the medical institution kept hidden under a blanket!

Fifty-six annual reports of well-known hospitals have been examined to see what they said about their out-patient work.\* The out-patient departments of these 56 hospitals had under treatment last year over a million persons; yet three-quarters of the annual reports made absolutely no mention of the fact that the hospital has an out-patient department, except such indication as is to be found in a brief statistical table of patients and visits.

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\*A postal was sent to about 250 hospitals, selected as among the leading ones in the country from the membership list of the American Hospital Association. Some were taken from every state in the Union. The postal card asked that an annual report be sent. In return 93 reports were received. Thirty-four of the 93 hospitals which sent reports had no out-patient department. Of the remaining number (59) 56 annual reports were received in time for tabulation.

All of the hospitals that did not send reports received a second postal card, so that 37% of responses represented the results of two requests.

Reports were also secured from a number of dispensaries not connected with hospitals, these not being included in the above figures.



A very well-known hospital in one of our largest cities issues a handsome report of 160 pages. The medical wards, the surgical, orthopedic, maternity, gynaecological, eye, children's, and neurological wards have each an "Auxiliary Committee," and each Auxiliary Committee presents a report of its special work, needs and financial supporters. Altogether these wards treated over 4,500 patients last year. The out-patient department of this hospital treated just about three times as many; but the out-patient department has no Auxiliary Committee; it has no special report; and, except for the statistical tables, one would only know that the hospital had an out-patient department from two sentences in the report of the President of the Board of Trustees to the effect that the dispensary service has been improved, that Social Service has been established, and that the patients in the dispensary have been supplied with individual drinking cups!

The report of this Board of Trustees is exceptional in one respect, namely, that the dispensary is mentioned at all. Only eight hospitals out of the 56 had any special report for the out-patient department in their annual report; and in three of these eight cases the "report" was merely a formal presentation of figures. There were also four hospitals which gave a little space to discussing the problems of the out-patient department, but did not dignify it by giving any special page or heading. Thus only 15% (nine out of 56) *said* anything about their out-patient department. Can it be true that an out-patient department may treat 1,000 or 20,000 human beings in a year and not have any problems or any needs?

Without entering further into the details gathered from these annual reports,\* enough has been said to

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\*As to out-patient statistics, all the hospitals except one mention the number of patients treated, and all except two give also the number of visits paid by these patients. Nearly one-third (17 out of 55) of these hospitals, however, give only the total number of patients and visits, and do not divide them according to the different clinical departments. If one examines a number of hospital reports, one is also forced to note with pain that 73% of them (42 out of 56) have no index or table of contents, so that it is necessary to hunt through a report of from 40 to 150 pages to find anything in it that one is looking for, such as out-patient statistics.

show the small number of the crumbs which the average hospital management throws to this poor relation at the hospital table. How can hospitals expect to get funds to improve out-patient work so long as they hide its light under a bushel?†

#### PRESENT FACTS OF OUT-PATIENT WORK.

For this Committee Report, facts have been gathered, through correspondence, concerning the present methods of organization and work of out-patient departments and dispensaries. Information is available from 76 institutions, of which 49 are hospitals and 27 dispensaries not connected with hospitals. While the number of hospitals is small, most of the large representative institutions having out-patient departments are included.

The facts appear tabulated as Appendix II. The more important items are\* :—

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All the hospital reports give the list of their medical staff, usually, though not invariably, classified under clinical departments. The diseases treated in the out-patient clinic were presented in a surprisingly large number of cases, considering the relatively small value of the information thus conveyed. Twenty-three out of 56 hospitals published a more or less extensive list of diseases treated, usually with the number of cases of each disease.

The reports of finances are of great negative interest. Thus out of 56 hospital reports:

7 gave no financial statement of any kind;

33 presented a financial statement, but not classified in such a way that the expenses of the out-patient department were either given or ascertainable;

16 presented a financial statement so itemized that the expenses of the out-patient department were separated.

†A suggested outline of what the annual report of a hospital should present concerning its out-patient department is printed as Appendix I.

\*A printed blank was sent, with a return envelope, to the 250 hospitals previously mentioned and to 34 dispensaries not connected with hospitals. Eighty-eight of these blanks were returned, and 76 were capable of tabulation. While this number represents a little less than a third of the out-patient departments and dispensaries in this country, excluding tuberculosis dispensaries, it does include almost all the larger and more representative institutions. Of course it must be remembered that a large proportion of the 250 hospitals that were communicated with had no out-patient departments.

1. *Organization.*—Seventy per cent. (31 out of 49) of the hospitals had no person in executive charge of the out-patient department. Of the 14 hospitals reporting a “permanent superintendent of out-patient work,” this official is evidently, in many cases, only a head nurse, and in others is an assistant superintendent of the hospital, who serves in the out-patient only for a fixed term. The out-patient department is, of course, under the authority of the superintendent of the hospital, but he obviously cannot undertake its actual supervision. Three well-known hospital superintendents have estimated the portion of their time which they charge financially to the out-patient department, presumably representing the amount of time directly given to out-patient supervision. These estimates were, respectively, 10%, 2% and 0%.

The typical arrangement, however, is for the out-patient department either to have in charge somebody who is interested in it, as a policeman is in his beat, to see that nothing goes wrong during his short period of incumbency; to have a head nurse or registrar, who does the best that a nurse or a clerk can do without authority or training to do more; or, finally, to have the dispensary run by its several departments, according to the method in which the ancient kings of Ireland are said to have conducted their affairs.

A very few institutions have recently placed a qualified person in responsible charge of the out-patient, with permanent tenure. How can an organization having a large working staff and dealing with thousands of persons, be efficient or progressive without an executive head, with real responsibility?

Of the 27 dispensaries not connected with hospitals, two-thirds (18 out of 27) say they have a “permanent Superintendent.” In most cases, however, this person is only a registrar or admitting clerk, and the dispensary really has as many executive heads as it has clinical departments.

2. *Payment of the Medical Staff.*—Six out of 49 hospitals pay all of their out-patient staff; three more pay some of them. All but two of these are out-patient departments of large general hospitals. A salaried staff is naturally much more frequent among the dispensaries unconnected with hospitals, only half of



which do not pay at least some of their medical men. Further facts indicate that while an apparently growing number of hospital and dispensary men desire a paid out-patient staff (if they had money to pay them!) there is a very considerable number (nearly half of the hospitals) who say that they do not believe in paying salaries to out-patient men.

3. *Social Service Department*.—Such departments are reported from 59% of the institutions, and are favored by 94%.

4. *Records*.—Seventy-two per cent. state that they make some record every time a patient visits the clinics; but only 60% have a list of the names and addresses of their patients.

5. *Technique of clinical work*.—Is it part of the routine, in medical clinics, to make laboratory tests of urine and blood for each patient, and to make a record of weight? In round numbers, 40% of the clinics report that they do this in some cases; 20% that they do so in all cases; and 40% that this work is not done at all. The proportions vary slightly between the tests of urine, blood and weight; urine being tested most frequently, weight next most frequently, and blood least frequently of the three. These figures refer in nearly all instances to the medical clinics only.

“Are physical examinations made, and recorded as a matter of routine, on the clinical record of each patient?” Forty-seven out of 76 institutions report that this is done in all cases,\* 15 say it is done in some cases that seem specially to call for it; 12 admit that it is not done at all.

6. *Dispensary Abuse*.—So much material has been collected on this topic that it will be published as a separate paper. The subject has been discussed with more length and more heat than any other in this field. One little group of facts must be included here. Thirty-six institutions—mostly very representative ones—have reported the number or percentage of applicants who were excluded from admission, in a given period, because they were “not proper subjects”; i.e., were thought able to pay a private physician. These

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\*While not always so specified in the returns, this undoubtedly refers in nearly all cases to the medical clinics only.

36 institutions treated approximately 520,000 out-patients last year:—

3 of the 36 excluded between 5% and 20% of the applicants.

5 of the 36 excluded between 2% and 5%.

7 " " " " 2% and  $\frac{1}{2}$  of 1%.

21 " " " less than  $\frac{1}{2}$  of 1%.

In other words, four-fifths of these 36 institutions excluded less than 2% of the applicants, and more than half refused a merely negligible number.

May not this conclusion be drawn? *The protection of the institutions and the medical profession from abuse by the small per cent. of improper subjects for out-patient treatment, is a necessary task; but the provision of efficient treatment for the 90% or 99% of patients who are admitted is a first essential.* Local conditions vary, and in some cities and some institutions this problem is larger than in others; yet, in general, what the out-patient service needs is a constructive program.

This further may be said, that the lack of agreement not only as to what can be done, but also as to what should be done, is nowhere more apparent in out-patient work than in dealing with this bugbear of "abuse."

7. *Cost and cost accounting.*—Schedules have been collected from six well-known institutions, showing how the superintendent estimated the cost of the out-patient service and of its various divisions. To present the details of these schedules, would suggest unfair comparisons. The following points may be made:

(1) The typical hospital does not maintain a considered segregation of the expenses of its out-patient department. Forty out of the 56 hospital annual reports (71%) previously referred to did not give the dispensary cost items separable from the hospital items.

(1) A relatively small number of hospitals do make a careful segregation of out-patient expenses; but each has its individual system, so that the expenses cannot be safely compared in detail.

(3) The *average cost per visit* of an out-patient is the best unit of expense, so far as a unit is desirable.

(4) Costs per visit vary widely, even among the institutions of high medical standing. The following table presents certain figures on this point:—

COMPARISON OF AVERAGE COST PER VISIT AT SIX OUT-PATIENT DEPARTMENTS.

Hospital or Dispen'y	Visits last year	Expen't's last year	Aver'ge cost per visit (in cents)	Remarks.
A.....	51,000	\$26,600	52c.	A dispensary not connected with a hospital.
B.....	69,600	23,500	33.8c.	An O.P.D. of a large general hospital.
C.....	115,000	55,000	47.8c.	A dispensary with a small hospital
D.....	132,000	24,000	18c.	Same remark as for B.
E.....	136,000	78,200	57c.	" " " "
F.....	236,000	43,700	18.5c.	" " " "

Thus of these six institutions giving the detailed schedules referred to, three spend approximately the same amount on out-patient service—\$25,000 a year. But the visits paid by patients to these three are, respectively, 51,000, 69,000 and 132,000; and the average cost per visit, therefore, respectively, 52 cents, 33 cents and 18 cents. Institutions D and E have approximately the same number of visits—a little over 130,000—paid by patients during the year; but one of these two institutions is spending \$24,000 in the year in its out-patient, and the other \$78,000, the average cost per visit being, therefore, 18 cents and 57 cents.

(5) Differences in average cost per out-patient visit are due partly to differences in organization, character of equipment, extent of medical teaching, etc.; partly to actual differences in standards of efficiency; and, finally, are partly factitious, owing to different methods of accounting.

(6) Although for these reasons comparisons of average cost per visit must be made with great caution when different institutions are compared, this cost unit is of the utmost value to every dispensary and out-patient department in the annual study of the progress of its own work. The greatest value of keeping good dispensary accounts is in self-criticism rather than in comparison.

(7) What shall we do about this matter of cost? If accurate and uniform cost figures for hospitals are still



difficult to get, must not accurate and uniform out-patient figures be inconceivable? The inconceivable, however, happens when it becomes necessary. With the rapid growth of out-patient work, and its assumption by municipal and state authorities, segregated dispensary accounting is a near necessity.

To draw up a form in which dispensary accounts should be classified, appears to be one of the most important and desirable pieces of work in this field. Such an assistance in accounting is needed, not only by out-patient departments of hospitals, but by the rapidly increasing number of dispensaries unconnected with hospitals. Such a form should not be complicated; but its preparation needs much care, and should be undertaken by a committee, as I shall suggest later.

#### PRESENT QUESTIONS AND PROBLEMS.

I take this occasion to speak of some needs of out-patient work which specially merit discussion because they are now, as it were, on the firing-line.

1. Should not every out-patient department or dispensary of any size, have a permanent Superintendent in responsible charge?

2. *More continuous and closely organized medical service.* The question of the payment of a physician for out-patient work arises here. On this point differences of opinion undoubtedly exist. A majority of those answering the question in the schedule believe that payment of physicians is desirable. The very respectable minority who gave a negative opinion may, it is true, have been partly impelled to do so by the belief that it is foolish to say you believe in paid doctors when you have no hope of getting money to pay them.

It is undoubtedly true that the increase in the amount of out-patient work which has come so rapidly, and the demand for higher standards of work which is certain to come—both contribute to increase the difficulty of securing enough good medical service without payment. The pressure falls first and most severely on the dispensaries not connected with important hospitals, but having teaching. Large hospitals, well known in their communities, and associated with medical schools, are likely to feel the pressure less or later.

There can be little doubt that a steady movement in the direction of paid services will take place. There can also be no doubt that the money to provide for paid services cannot be secured until the public is more fully and intelligently informed about the needs and the importance of out-patient work.

3. *Social Service Departments* must be largely developed and organized closely in conjunction with the nursing service in the clinics and in the patients' homes.

4. *Admission systems* must be planned not only to keep the so-called "unworthy" out, but to reveal otherwise undiscovered needs of the so-called "worthy" who are admitted. A properly trained person at an admission desk is in a strategic position to benefit every phase of the dispensary's work. The use of a member or members of the Social Service Department in this position is, and should be, increasing.

5. *Should patients be charged any fees?* A speaker at last year's session of this Association answered this question in the negative. The reason was apparently in part from the belief that if a dispensary is a charity, it should not dispense charity at a price, but charity *straight*. Another argument purports to show that nominal fees cheapen medical service. A committee of the New York County Medical Society, in a recent report, suggested a further objection to the fee system; namely, that because the medicine and supplies used were thus paid for, the "burden of the charity of the dispensary" was "left exclusively on the medical profession," and that "charitable institutions should dispense charity to the extent of their ability and no more; that they should not make money for the purpose of extending their work . . . . We believe the dispensary should be maintained for the benefit of the poor only." The impulse toward this trend of thought may possibly have been a feeling that dispensary work has gone too far in New York, and that anything that can be done to limit it, such as cutting down the resources of the dispensaries by limiting fees, will be a good thing.

Does "poor" mean destitute? Is not poverty a relative term? Are out-patient departments medical soup-kitchens? Is the test of fitness for dispensary treatment the inability to pay ten cents, or the inability to pay for

the medical care needed to maintain health and working efficiency?

Small fees paid by the patient at each visit, and for medicines, etc., are, if rightly managed, a boon to an out-patient department. They bring not only some money, but distinctive administrative advantages. They promote better records, tighten lines of responsibility, and necessitate some one in charge of the admission system who has sufficient authority to decide who shall be admitted without fees. If no persons are let in who have too much money, and no persons are turned away who have no money, may we not satisfy both those who are anxious to prevent abuse and those who burn to do straight charity?

6. *Efficiency tests.*—Business experts have come to the belief that when a man spends a thousand dollars for getting certain results, but does not spend one dollar for testing what those results are, he has wasted some of that thousand dollars. The out-patient departments and hospitals of this country are spending millions of dollars yearly in treating patients. How much are they spending in testing results of treatment? Are efficiency tests practicable in such a complex and personal thing as the medical treatment of out-patients? With the understanding that all tests have to be applied with a common-sense view of their limitations, I think they are of value; in fact, are a necessity. Three practicable efficiency tests will be mentioned.

(1) *Number of visits per patient.* If you find that 35% of cases of acute gonorrhea pay only one visit to your men's genito-urinary clinic, and if 60% pay not more than two visits, will you consider the treatment in that clinic efficient? If in a certain medical service the average number of visits per patient is  $1\frac{1}{2}$  and if during another service it is 3. plus, by which service would *you* rather be treated?

The number of visits paid by a patient is a figure easily ascertained, wherever elementary records are kept. When the patients or their records are taken in groups in which all have the same diagnosis or similar diagnoses, we can arrive at valuable conclusions. Comparisons between clinics in different institutions or even different services in the same clinic, must always be made with caution, but with reason-



able safeguards in interpretation, the *number of visits per patient, classified by diagnosis*, will be found a highly useful efficiency index. The amount of waste work that is found to be spent on patients who pay only one or two visits, when effective treatment clearly calls for several visits, usually stirs up the medical and lay authorities of an institution as much as anything can.

(2) *Medical results analysed on consecutive cases.* When records are carefully kept a clinical physician can take a number of patients with a given diagnosis and classify the results achieved as "cured," "materially improved," "pending" or "lost" because of failure to return. It is essential to take cases in consecutive order so as not to exercise selection. This test goes deeper than the preceding, but takes much more time and is too dependent upon full and accurate records to be generally available in out-patient clinics at present.

(3) *Medical-Social Surveys of Clinical Work.* A hundred or more cases may be taken (consecutively or at random) from a particular clinic, or from an institution as a whole. Then, a certain period after the diagnosis has been made in the out-patient clinic, a visit may be paid by a properly trained nurse or social worker to the home, and a report made to the physician of the patient's condition, or the patient may be brought back and again examined. In either case this method makes it possible to study the work which was actually accomplished by the dispensary for a group of patients, the number who made one visit and never came back, the probable reason for the failure to return; at the other extreme the number who were cured or substantially benefited. Finally we shall get a glimpse of the home conditions of poverty, ignorance, unemployment or neglect, which very often militate against successful treatment by the physician, and which without the assistance of a social worker, cannot be overcome.

Such surveys have been conducted in at least two institutions and have proved to be of great benefit. This value is not merely in criticism; for such surveys give positive suggestions as to how existing resources may be used to improve treatment. They also serve to provide facts upon which appeals can be made for funds for more resources.

## 7. Civic Problems.

(a) *Licensing of Dispensaries by State law.* New York and Colorado are the only states which have done this, but with the growth of both reputable and disreputable dispensaries, such legal regulation is certain to extend elsewhere.

(b) *Regulation or supervision of dispensaries* by the municipal Board of Health has appeared to some extent, and is also likely to increase.

(c) *Co-operative arrangements* among the out-patient departments and dispensaries of a city. The Associated Out-Patient Clinics of New York City have made a notable beginning in this direction. Such associations must ultimately be brought about in all large cities, both for the purpose of mutual protection of reputable dispensaries against abuse and for the positive aim of mutual assistance in establishing and maintaining high standards.

(d) *Municipal support or control of dispensary work.* This subject received some attention in the Out-Patient Committee Report last year, but I am unable to agree entirely with the conclusion therein reached. The pressure for funds and the probability that the need of paying physicians for out-patient service will increase, have caused many persons to think seriously that the only solution of the financial question is the assumption of dispensary work by city authorities. The activities of government are widening rapidly in many directions, as we all know, but it seems to me that, in the few localities with which I am familiar, it is premature to present a program of city ownership and control of dispensary work.

At least, I am confident that the development of standards of dispensary work is a prior necessity. Methods of out-patient service are not yet sufficiently worked out, agreed upon and standardized, to expect that many municipalities can fairly be asked to take over all local out-patient departments and dispensaries and deal justly by them. Those of us who are now concerned with administering out-patient work, have the present responsibility of working out standards, before we are justified in coming forward with a general program for municipal dispensaries on a large scale.

## A COMMITTEE ON METHODS OF OUT-PATIENT SERVICE.

Much has been said in this paper upon the need of standards, and with a few more words on it I shall conclude. It has seemed to me that the American Hospital Association bears a special responsibility in this matter. The American Medical Association has a committee on "Dispensary Abuse," but there is nowhere a committee to do constructive work on the dispensary problem. The American Medical Association stands primarily for the interests of the medical profession. The Hospital Association, on the other hand, is in the peculiarly fortunate position of representing the joint interests of the medical profession and the lay public, through which the financial support of medical institutions chiefly comes. Standards and methods used in out-patient institutions are a matter of interest to the general public because they vitally concern public health. It would seem fitting and practical if the American Hospital Association should think it proper to have a Committee, say, of five members, appointed as a Committee on Methods of Out-patient Service. A committee of one, which has been appointed during the last two years, is capable of presenting a report such as that which you are enduring, but a committee of one cannot be representative.

What is needed now is a carefully-worked-out, concrete statement of at least minimum requisites for efficient service in an out-patient department or dispensary. There is nothing of this kind now available. I therefore urge that such a committee be appointed to present a report at the next meeting of this Association.

Perhaps it will be said that the superintendents of hospitals and dispensaries know very well today what is needed to improve out-patient work—money. Money is a most convenient necessity, I admit; but money must be secured by persuading somebody to give it—either municipal or state legislatures or private individuals endowed with philanthropic instincts *and* means. It is not easy to get money for something which the public does not know much about, and which is not given much apparent consideration by those who are supposed to have expert knowledge of it. In just such a condition



are the out-patient department and the dispensary today.

Two things are required before adequate support for dispensary work can be expected: *facts and a program*. Facts we must have, showing what the results of dispensary work can be, what the results under existing conditions are, and what is needed to make the results better. Outlines, drawn up by recognized authority, suggesting the requisites for efficient results, will be the greatest possible leverage in the hands of those who wish funds from public or private sources to place dispensary work on a higher plane. Facts and standards are the pre-requisites to a program of improvement. Public authorities and private givers like to know what is going to be returned for their money, and to have a definite program presented, before they are willing to do what the boys call "shell out."

If we read many signs of the times aright, the utilization of out-patient clinics for the treatment of sickness and the prevention of disease is going to increase rapidly. The out-patient department or dispensary is already playing a great and growing part in the anti-tuberculosis campaign; the campaign against the hook-worm has employed it on a large scale; the dispensary method has been adopted in the fight against infant mortality, and every summer now sees an increase in this field. Out-patient service is thrown more and more into the foreground by such influences as the rising cost of living; the increase in the cost of medical service; the recognized difficulty of providing competent specialists at prices within the reach of even the middle classes; and, perhaps more than all, the growing public demand for better care of the health of children. Workmen's Compensation laws, already established in many states, and other forms of social insurance which are in the field of political discussion—are bringing to this country, as they have brought to Germany, England, and other nations abroad, serious questions involving radical changes in the character of medical service to the mass of the people. These problems must be attacked from a broad standpoint which considers both the interests of the medical profession and those of the general public together.

The establishment of higher standards of out-patient service; the elaboration of a technique by which the treatment of out-patients can be made thoroughly efficient—are the immediate problems which we are facing. The solution of these problems of efficiency is a pre-requisite to the larger utilization of the dispensary as a constructive and permanent agent of promoting public health.

## APPENDIX I.

Suggestions of material which the Annual Report of a Hospital should contain, concerning its Out-Patient Department.

1. *Arrangement.*—The opening portion of the Annual Report should give an idea of *all* the divisions of the hospital, and should put them in some perspective. Every report should have a table of contents.

2. *A Special Report for the Out-Patient Department.*—Every hospital in which the number of out-patients equals or exceeds the number of ward patients should give a special section of its report to the out-patient department, as a division of the hospital work. Such a report might be a section of the trustees' or superintendent's report, or it might be a report of a special committee on the out-patient department. Such a special report ought to contain:—

An idea of the general organization of the dispensary and of its medical service. It is probably well to print detailed statistics of the dispensary in the statistical section of the report, and only the general figures here.

Changes during the past year which have taken place in relation to such matters, as building, equipment, medical staff, executive staff, clinical methods, social service, etc.

Something about the problems of the work. The public really ought to be given the impression that the authorities of the hospital are *thinking* a little about the dispensary as well as running off clinics.

3. *Out-Patient Statistics.* The Report should state, for the period covered by it, (1) the number of patients, classified by clinical departments; (2) The number of visits made by these patients, classified by departments; (3) The average number of visits per patient for each department.

Statistics of special work—X-Ray, social service department, etc., should be given.\*

4. *Finances.*—The cost of the out-patient department should be included in the Treasurer's Report, itemized so far as practicable.  
and the income from fees paid by patients, if any,

5. *Regulations Concerning Admission and Treatment.*—The rules governing admission of out-patients, the days and hours on which clinics are open, the class of patients taken, and the fees charged, if any, should be stated succinctly in every Report. Ninety per cent. of the 56 reports give no such information.

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\* The list of diseases treated is not included among the foregoing "requisites." The value of such a list, if carefully classified, is not questioned; but the amount of labor in preparing it is relatively so great that, if a choice is to be made between presenting it and the facts above mentioned, it seems that the facts above mentioned ought to come first.



## APPENDIX II.

## Organization and Methods of Out-Patient Work in 76 Institutions.

	19 Large Hospitals				18 Small Hospitals				12 Special Hospit's				12 Large Dispen'r's				15 Small Dispen'r's				Totals		Not Partly ans.
	Yes	No	Partly	Yes	No	Partly	Yes	No	Partly	Yes	No	Partly	Yes	No	Partly	Yes	No	Partly	Yes	No	Partly	Yes	No
Paid doctors .....	4	12	3	1	17	..	1	10	..	5	3	3	3	10	2	14	52	8					2
Believe in or favor paid doctors .....	9	3	3	6	9	..	3	5	..	10	2	..	7	5	..	35	24	3					14
A permanent Supt.	8	11	..	3	15	..	3	8	?	10	2	..	9	6	..	32	42	1					0
A Social Service Department ....	12	2	..	8	5	..	7	5	..	8	4	..	6	9	..	41	25	0					0
Favor Social Ser- vice Dept. ....	19	..	..	16	1	..	12	..	..	12	..	..	12	2	..	71	3	0					2
Rec'ds kept on cards	13	0	6	11	5	2	9	1	2	4	5	3	9	3	3	46	14	16					0
Patients' visits re- corded .....	12	2	5	14	3	1	11	0	1	7	2	3	11	3	1	55	10	11					0
Index of patients kept .....	12	6	1	8	9	..	10	1	1	6	6	..	8	7	..	44	29	2					1
Physical exam. re- corded in all cases	13	1	..	8	4	..	4	..	..	7	4	?	8	3	..	47	12	1					1
"In some cases"	5	..	..	5	..	..	1	..	..	..	..	..	4	..	..	15	..	..					..
Test of Urine a clinical routine..	2	6	11	3	8	7	5	1	6	4	3	?	3	8	4	17	26	32					1
Test of Blood a clinical routine..	1	7	11	2	10	5	2	2	8	2	4	?	3	8	4	10	31	34					1
Weighing Patient a clinical routine..	1	7	11	3	9	6	5	1	6	5	4	3	2	9	4	10	30	30					0

OUT-PATIENT WORK

(b) Form\* for classifying Medical Results correlated with number of visits paid.  
 EFFICIENCY TEST IN .....DEPARTMENT  
 for months of .....191  
 Diagnoses Tabulated .....

Visits per Patient	MEDICAL RESULTS						Total Number of Cases	Percent
	Continued Treatment, discharged cured	Continued treatment ceased or was discharged improved.	Ditto, not improved.	Treatment pursued & now continuing.	Case transferred to care of another Medical or Social Agency	Result unsatisfactory: patient failed to return for treatment. "Lost Cases"	Medical Outcome Unknown.	
One								
Two								
Three								
Four								
Five								
Six to Eight								
Nine to Twelve								
Over Twelve								
Totals								
Percentages								

\*Printed copies of these forms may be obtained by addressing the author at 25 Bennet Street, Boston, Mass.





## DISCUSSION.

PRESIDENT: This paper of Mr. Davis' is a very interesting and instructive paper. Perhaps the President will be excused if he makes one or two remarks. As to municipal control of dispensaries, would it not be well to wait until municipalities do well what they have undertaken now before they take up this work. As for dispensary abuse, of which we have heard so much, the older I grow and the more years that I have to do with out-patient departments of hospitals, the less sympathy I have with this talk of dispensary abuse, and the more sympathy I have with the patient who is turned away and sent into the hands of some physician, or some medical institute where he will not get the care that he needs. I have less and less patience with this talk of dispensary abuse. Mr. Davis has made a recommendation that a Committee on Out-Patient Departments be appointed for the ensuing year. The by-laws call for a committee of one. I take it that there will be no objection to the incoming President adding to this committee. It certainly is a most important subject and one which, as Mr. Davis has said, has been so far neglected in most parts of the country. There are a few hospitals in the country that have done out-patient work as they should do it and they have plenty of room for improvement. Is there any further discussion on this paper?

DR. FOWLER: I beg the pardon of the meeting for appearing so often, but I am an enthusiast along hospital lines, and the remarks made by the distinguished essayist and the President have caused me to attempt to say something in response. As you know I am superintendent of the City Hospital of Louisville, Kentucky, and we treat on an average 125 people a day in our out-patient department and expend something like \$15,000 per annum, and we think we do it well. We keep specific records, and four hours in the morning we put a staff officer in there, not an interne, and four hours in the afternoon, and the other four hours are taken care of by the internes, by the house staff; so we do not lose an hour in the day in treating those poor people that come from all over the city, some of them walking five or six miles, and we also honor every prescription marked "Charity" by any physician in the city, and in addition to that we furnish every nurse, all the district nurses, all the King's Daughters nurses, all the Jewish charity nurses, in fact, all those institutions, with anything that they demand, their daily supplies in visiting the poor over the city, and I believe that the city is the only one to get back to a movement of that kind. My experience has been with the other organizations that that is why they came to us, that they could not raise the money, but my city has been extremely liberal and have authorized me as Superintendent never to stop at any expense. I have spent as much as \$11¢ buying serum for one child. That is the remark that I desire to make.

PRESIDENT: It is refreshing to hear of a city which is so well conducted. Are there any further remarks on Mr. Davis' paper? If not we will go to the next paper.

## THE HOSPITAL AND DISPENSARY AND SOCIAL REFORM.

SIDNEY E. GOLDSTEIN, Director.

Free Synagogue, New York City.

The Hospital and Dispensary Problem has two sides—the inside and the outside. Eight years ago it was my privilege to serve as Assistant Superintendent of Mt. Sinai Hospital, New York, under Dr. Sigmund S. Goldwater. The work and study in this position and the association with the foremost hospital administrator in America gave me some understanding of the hospital and dispensary from the inside. In 1907 Dr. Stephen S. Wise organized the Free Synagogue of New York and honored me with the position of Director of Social Service. In the six years of our activities we have developed four sections: One in General Medical Social Service, covering medical, surgical and maternity cases; one in Medical Social Service with the tuberculosis; one in Infant Hygiene; and one in Mental Hygiene. The work has been done largely in Bellevue and Lebanon Hospitals of New York City. In doing this work we are spending \$18,000 this year exclusive of administrative expenses; and our different sections bring under our care between 5,000 and 6,000 patients a year. The social study and treatment of these men, women and children, and families broken down through sickness, has given me something of the hospital and dispensary from the outside. It has made me ask many questions, some pertinent; some perhaps impertinent.

The hospital and dispensary like any other public institution is a social investment. Is this social investment yielding a maximum dividend to Society? In this century of scientific management and efficiency engineers we may not content ourselves with accepted standards in institutional routine. Perhaps better and bigger work can be done with some other system and with a larger vision. A few years ago the school plant was in use five hours a day, five days a week. There were many who thought it sacrilege to invade its precincts at any other time and for any other purpose

other than the instruction of school children. Today the buildings in which our children are being educated are employed as social centers, and in a short time the investment will be paying, in quantity at least, a maximum return to the stock-holders. Sometimes it seems that of all our public institutions the hospitals and dispensaries are the least affected by this new spirit that is at work in the land, and that is re-socializing all our so-called social agencies and institutions: The Government, the Church, the Synagogue, the Reformatory, the Prison and the School. Sometimes it seems not unfair to say that those in charge of hospitals and dispensaries only dimly discern the larger things that these institutions are to do, and that Society has come rightfully to expect and exact of them. The causes are many; some easily understood and acceptable, others irritating and intolerable. The consequences, therefore, are what arouse our solicitude and give us pause.

Beginning with the foundation—with the building itself. Here is a large dispensary typical of a thousand others. It is situated in the midst of a poor and overpopulated district. The corridors and rooms are crowded; the congestion is so great and the resulting conditions so serious that it is impossible to treat the patients properly, or to achieve any lasting results. No change, however, takes place from month to month, or from year to year except that the picture grows more distressing as time passes. Why? The doctors give their reasons, the superintendents and members of the boards give theirs. The fact is that the dispensary building and equipment are not utilized to the utmost capacity. They are capable of being used three times a day: morning, afternoon and evening. They are, however, not rendering this maximum service. In Greater New York, there are 108 dispensaries, general and special. Some are open in the morning; some in the afternoon; some in part in the morning; in part in the afternoon; a few have clinics in the evening. Not one is employing the full capacity of the plant. To what degree is congestion, the scandal of medical work, due? To the fact that patients are crowded into a few hours of the day. To what degree would this congestion be relieved if the patients were distributed over the morning, afternoon and evening ses-



sions? It is premature, it seems to me, to seek other solutions of the dispensary problem until we discover what such a distribution and re-arrangement would accomplish. The dispensary is capable of giving much more than we are now taking out of it—even in such elemental matters as time and space.

There is a special reason, furthermore, that the dispensary should be open in the evening. Dispensary patients are ambulant patients; the clientel is composed largely of men and women who are able to be up and around, and many are able to work at their trade. If clinics can be visited only in the morning or afternoon, it means one or the other of two things: either the men and women who are able to work during the day must lose time and wages in order to attend the dispensary—a serious loss when we consider that a day's earning is a day's support; or it may mean that men and women who are ill will not seek advice and relief until the disease has progressed to the point where they can no longer bear it, and when it has reached the stage when it is much less amenable to medical ministration. A tragic commentary in this connection is found in the statistics of the Bellevue Hospital Tuberculosis Clinic :

	Number in				Percentage in			
	1912	1911	1910	1909	1912	1911	1910	1909
Incipient . . . . .	471	383	506	635	43%	40%	43%	46%
Moder'tly adv'd	446	379	488	545	40%	40%	41%	40%
Far advanced.	186	188	186	191	17%	20%	18%	14%

This table shows that of 4,606 patients discharged in the four years of, 1909, 1910, 1911 and 1912 only 40% were in the incipient stage at date of first examination. The percentage remains practically stationary for the entire four years. Sixty per cent. were in the moderately advanced or far advanced stage when they first applied for treatment. Knowing the working class as we do, knowing how loath they are to lose a day's wages in order to see a doctor, one cannot resist the question: How many of the 60 per cent. would have sought counsel earlier had the clinic in this district been open every night? How many could have been saved? Of all the large dispensaries in Greater New York only one, St. Bartholomew's, is open in all its important branches every evening; and, it is significant

to note in passing that this dispensary was established not by a hospital or a group of physicians or their friends, but by a religious organization. With this one exception and a few others that maintain Nose, Throat, Genito Urinary, and Mental Hygiene Departments, and the Board of Health that has here and there a tuberculosis clinic open one evening in the week, it seems that the dispensaries of our Metropolis are not organized and administered with the needs of the people they are expected to serve foremost in mind. The oft-repeated objection, that physicians will not volunteer their services for evening work, is without foundation. St. Bartholomew's has no difficulty in securing men for its sessions, and we in the Free Synagogue have found no difficulty in building up an expert staff of psychiatrists in our Mental Hygiene Clinic.

Another question is this: Cannot the dispensary with its building and equipment, its staff of physicians and nurses, its growing Social Service Department, do something more than merely treat disease? Here and there light has appeared on the horizon. In the Bellevue Dispensary a class for cardiac cases is conducted on Friday nights. In this class men and women with heart trouble are taught what not to do, and how to avoid the acute condition that sends them to a hospital bed. Other classes are being organized elsewhere. In Lebanon Hospital we organized a year ago last month the Infant Hygiene Clinic. This Clinic is open twice a week and here the mothers are instructed how to feed and wash and dress their babies. In the year just closed 277 infants were under care; 1,500 visits were made to homes; the total mortality for the year was 3%. Only two babies died of mal-nutrition. In the Fall we shall inaugurate a course of lectures under the auspices of the Social Service Department that shall deal with the elements of hygiene and sanitation. Why cannot such work be extended and multiplied? The purpose ought to be not to make sick people well, but well people better.

Some Social Service Workers are pessimistic in thinking about the dispensary. They regard it as a discredited and almost irredeemable institution. In my opinion the dispensary is on the threshold of a new epoch. It is designed to do a large work in the com-

munity and will soon rise to its wider opportunities. New forces are operating in many cities. Dr. Richard Cabot, of Boston, has led in the fight. The emphasis and support, I believe, is going to shift from the hospital proper to the Out-Patient Department. We shall soon realize that the function of the Out-Patient Department is to keep patients out of the hospital. The only argument that can be urged against these reforms is this: Funds are lacking. The truth is this is merely an impediment, and not an argument. Public health is just as important as public education and is more fundamental, and the institution that by virtue of its character and position can most readily concern itself with the health of the community, will not fail of funds when its possibilities are completely appreciated.

The hospital itself cannot be charged with the same weakness and ineptitude as the dispensary. The hospital is running at full capacity, but there are many other ways in which this institution could be far more serviceable to society than it is today. Time will permit me to name only one. In the archives of every hospital are found medical histories of the patients. These histories with their wealth of fact and description constitute a most available source of information for students of medicine and surgery. Why should these histories not be supplemented by histories of another character—by a description of the patients' social condition and disease? It is just to request that facts which the doctors alone could discover should be tabulated and arranged in such a manner that they can be readily converted into material for social study. Information concerning habits and occupation, home and tenement conditions, should be written out and placed at our disposal. In many movements for social reform small use can be made of the vast amount of evidence and argument that could be found in hospital records because the hospital makes no effort to present this material in accessible form. Two years ago when the lead poisoning industry was under investigation it became necessary to search out patients in their homes after they had been in the hospital. The time and trouble that this took, and the losses that we suffered could all have been saved had the hospital taken and preserved the social history of each case.



Here are some further questions that cannot at present be answered with any degree of accuracy. How many times does a man go to a hospital in one year—in five years: how much does his care cost the community? How many cases of pneumonia and pleurisy treated in our hospitals are followed by tuberculosis; how many of such cases of tuberculosis could be prevented? How many unmarried mothers are treated in the maternity wards of our hospitals; how many of these are defective or deranged? How much does a tenement block cost the public in hospital care? How much does a given industry cost the country? In 1908, the summer following the panic, I went to Pittsburgh to study the hospital and dispensary system for the Russell Sage Foundation. I left New York with the wards overflowing in every institution. The next day in Pittsburgh I found most of the surgical wards empty; the beds and chairs and tables stacked up in corners. We immediately searched for the cause of this anomalous situation. It did not take long to discover it. The surgical wards of the Pittsburgh hospitals were empty because the steel mills were closed. The surgical census of the hospitals rises and falls with the movement of the industry. If we had the social histories of these hospital cases it would be found, I believe, that the steel mills are turning out broken bones, crushed bodies, mutilated men with the same heartless regularity that they are turning out steel rails and armor plate. Men are fed into the industry as ore is poured into the blast furnaces. The labor is melted out and runs off in gold; the men drop to the bottom and are raked out as slag.

To sum up the recommendations that I wish to urge upon the representatives of the hospitals and dispensaries in America are these:

1. That every possible effort be made to increase the hours of service in the dispensary in order that the present congestion may be broken up.
2. That evening clinics for men and women be multiplied in order that the institutions may be more serviceable to those who need them most.
3. That the dispensary make an earnest endeavor to develop its educational opportunities and activities in order that it may soon become, what it is destined to be, an agent of health in the community.

4. That the hospital, through the Social Service Department, prepare a social history of every case in order that through these histories we may come to a better understanding and re-statement of sickness as a social problem, and in order that with this evidence in our hands we may more speedily achieve various social reforms.

Such work on the part of hospitals and dispensaries would, I am convinced, exercise a lasting influence upon fear, distrust or prejudice from which these institutions now unjustly suffer on the part of the community. It would teach men and women that the hospital and dispensary are vitally interested in the welfare of all, and would bring to these institutions greater support and larger contributions. Let there be added to the present intense medical interest and highly developed administrative ability more of the communal spirit and a large social vision, and a new era will open in the health work of our cities. The time is near at hand when the hospital and dispensary will lose their formidable aspect; when they will cease to be merely reception houses for the sick; when they will be the custodians and guardians of the physical welfare of the communities in which they are situated; when they will contribute their full share to social reform, and the reconstruction of our social life.

#### DISCUSSION.

PRESIDENT: Is there any discussion upon Mr. Goldstein's most interesting paper, for which we are greatly indebted to him? If not, we will proceed with the next paper.

DR. GOLDWATER: Mr. Chairman, Ladies and Gentlemen: It was not my purpose to discuss either of the papers that you have just heard, but I think it would be a sign of painful indifference on the part of this Association if the reading of these two papers were allowed to pass without any comment. Some five or six years ago this Association adopted a By-law providing for an annual report by some one on dispensary progress during the year. The object of those who caused that resolution to be enacted was to concentrate the attention of the members of this Association at least once each year upon the tremendously important and vital problems that are involved in dispensary management. The comprehensive survey of dispensary work as it is commonly performed today, and of dispensary needs as we all know them to exist, which Mr. Davis has just presented, justifies, I think the action of those who persuaded the Associa-

tion to give systematic and periodic attention to dispensary problems. There are a number of things in Mr. Davis' paper that might be discussed at length, there are two or three to which I wish to refer by way of supporting the suggestions which the speaker made.

Take the important matter of dispensary costs. While we have all been interested for years in the matter of per capita cost of hospital patients, comparatively few of us have paid any attention to the cost of dispensary patients and that has led, I think, to a false understanding on the part of hospital managers as to precisely what the financial and moral obligations are that are involved in the conduct of dispensaries. If it had been pointed out to dispensary managers in a given instance that the cost of each dispensary consultation was, say, two or three or four cents. I think it would appeal to the common sense of the dispensary managers at once that comparatively little could be done in the way of relieving dispensary patients at such a small cost because little as they may know about what dispensary work consists of, they know that drugs cost money, they know the construction cost of buildings and their maintenance are considerable, and they must realize that if the sum total of the cost of everything that is lavished on dispensary patients amounts to the grand total of four cents, they will see at a glance that there is something wrong with the dispensary, and an investigation will speedily be instituted.

There is a great deal of bitterness among doctors about their relation to dispensaries, about the lack of consideration shown them, and I am inclined to think that the constant agitation against dispensaries emanates from the doctors' feeling that dispensaries are much-abused charities. I think there may be an explanation for all this. You can scarcely blame the physician who is not familiar with the analysis of hospital financial reports if he concludes that he and his colleagues are being exploited if, when he takes up the report of a given institution he reads in the summary of its expenses and of its income the statement that the cost of the dispensary in a given year was \$10,000 and that the fees collected from dispensary patients who were supposed to get their treatment for nothing, was \$20,000. I have known so much bitterness to arise in a given institution as the result of misleading statistics of that sort as to cause rebellion. There was an undercurrent of rebellious feeling for years, and it was only after private and confidential talks with certain members of the staff that they were persuaded that they had a real misunderstanding of the facts. As a matter of fact the dispensary in question cost not \$10,000, but \$45,000 a year, but the annual report was so composed that most of the actual dispensary expenses were distributed under other heads. Thus the cost of maintaining the building did not appear, the cost of caring for the nurses who worked in the dispensary during all or part of their time did not appear; in fact, the only costs actually charged against the dispensary were those of the minor help at work in the dispensary building and of certain designated supplies.

I think it is a hopeful sign that more money is being spent almost everywhere in dispensaries. I think that this tendency



to spend more thoughtfully and more liberally, as much as any other one fact justifies those who are optimistic in regard to the future of dispensaries. Not many years ago the average cost of consultations at representative dispensaries was about seven cents per capita. That cost has since risen to a figure approximating fifteen cents. There are dispensaries where as much as thirty cents is being spent on each consultation, and there is one in this city, where the cost of each dispensary consultation, with all that goes with it, amounts to approximately forty cents.

PRESIDENT: If you add to that social service it amounts to eighty cents.

DR. GOLDWATER: I want to refer particularly to social service work. Curious things are happening, we are getting results we did not anticipate and did not plan for. When tuberculosis clinics were first organized in New York, it was with the idea that by sending nurses into patients' homes we would be able to correct faults of living and perhaps discover incipient hitherto unrecognized cases which might be directed to a better way of living. Though we never hoped that the tuberculosis dispensary would put down tuberculosis, it was hoped that tuberculosis would be checked and in some cases cured by the new social service methods. A careful analysis of the tuberculosis work done in New York today shows that if the expectation was that it would bring about the cure of tuberculosis, that if that be the only standard by which the tuberculosis clinic can be justified, it must be reckoned a failure today. But in other ways the tuberculosis clinic is doing work that is of vast social importance. The phase of the work which we regard as having real value today, is the work that the nurses do in getting in touch with the children in the families where tuberculosis exists and in seeing that the health of those children is guarded as the health of children should be. The parents are unable to provide for them, the children ordinarily are granted no change of scene, no change of air; in many instances they are improperly and insufficiently fed; they are not treated as children should be treated, if we have any thought of conserving the life of the child. Our nurses are giving most of their attention to the needs of these children, and in doing so they are dealing with a problem that is easily grasped, a problem which appeals to everybody and one which can be solved, whereas the problem of tuberculosis *per se* is difficult to solve.

Now as to money. It was feared that the rapid advance of social service work would absorb funds that would otherwise go to the general purposes of the dispensary, but investigation shows that this is not the case. In dispensary after dispensary, where the three or four-cent standard existed, where the work was done in slipshod ways, the introduction of tuberculosis clinic was followed at once by the raising of money and spending of money to the extent of fifteen to twenty cents per patient. Today these figures are not at all uncommon, and you will find that in dispensaries where there exists a full knowledge of the facts presented by study of social backgrounds, there is no difficulty whatever about raising the money required to conduct

social service departments. Why stop with a social service staff with a single department? Why not apply this general principle of studying the social background and dealing intelligently and intentionally with the causes of disease, to all the departments of the dispensary? The tuberculosis clinic is a beginning, not a finality.

The efficiency test is of course a valuable thing, but there are efficiency tests *and* efficiency tests. Recently I was asked to look over an alleged efficiency test in an institution in New York City, and the man conducting this test showed me a figure based upon some investigations connected with the dispensary. The conclusion reached by the investigator was that something like ninety per cent. of the patients obtained no result from their dispensary visits, when I asked by what standard he measured the results, he was very hazy about it, as a matter of fact he had no standard. His practice was to go to the home of a patient and to ask whether the patient considered that he had been benefited; if the patient thought he was not benefited and the home looked neglected and conditions were not as they should be, the report was that the patient had not been benefited by the dispensary treatment. But there was no attempt to ascertain what the precise condition of the patient was when he came to the dispensary. Oftentimes the patient was suffering from conditions with which the dispensary had nothing to do, and the failure to remedy such conditions could not reasonably be charged against the dispensary, so the efficiency test itself, it seemed to me, was without value. I mention this by way of suggesting to those who wish to make efficiency tests that they should consider very carefully their conclusions and the facts upon which they are based. There is, goodness knows, enough about dispensary work that is wrong, but I think we ought to be perfectly logical when we charge dispensaries with inefficiency and ought to be able to prove that the inefficiency is the inefficiency of the dispensary and not the inefficiency of Society.

Mr. Davis spoke of the movement in regard to standardizing dispensaries and of the Association of Out-Patient Clinics, to which 41 dispensaries in New York City have declared their allegiance. I do not know how much the Association will accomplish, but I think it will work out a method for the study of dispensary problems. It proposes to concern itself with standards of many kinds, with standards of construction, with standards of equipment of individual departments. Much has been written about construction and equipment of hospitals, almost nothing about the construction and equipment of dispensaries. The Association proposes to concern itself with almost all the questions referred to by Mr. Davis, the question of salaries, organization, etc. When the work of the Associated Clinics was started it was assumed by many of us that it would be easy in six months or a year of careful consideration of dispensary problems to work out a comprehensive plan for the construction, organization and management of dispensaries. But we have found that we knew comparatively little about the work. If dispensaries are to be standardized, they should be standardized department by department. We want dispensaries to be substantially built, with space for the seating of all the

visitors; we want decency, we want consideration for the needs of every patient. We want to know whom we are dealing with, we want to know if the patient has a right to be there and whether he carries out instructions. These suggest general standards. Entirely apart from that are the problems that come up in connection with individual departments.

The question, for instance, came up in New York whether the Department of Health should undertake the treatment of venereal diseases. No serious effort had yet been made in connection with dispensaries to deal with venereal diseases. In certain dispensaries these cases were treated in the medical department, in other dispensaries a patient might be treated first in "general medicine," then as tertiary symptoms came on he might be referred to another department. Each case was not handled as an individual case throughout its history. There was no connected history and what little information was given in the records did not show whether treatment was efficient or inefficient. The efficient treatment of syphilis demands the liberal application of salvarsan; it is rather an expensive business and the dispensaries fight shy of it. If a dispensary has been spending ten cents per patient the idea of spending \$5 or \$10 for more efficient treatment is startling, to say the least. But it appears that many of the men who apply for treatment for venereal disease are single men, supporting themselves, and able to pay their way; and that many of the more intelligent came to the dispensary because there is no private physician in whom they have confidence. The question of handling venereal cases, we found, was so involved and demanded so much technical knowledge, that the dispensary administrators were not able to face all the questions and answer them intelligently; so the Association proceeded to organize a section on venereal diseases of the Associated Out-Patient Clinics and that section, after four or five sessions, finally elaborated a program for the dispensary treatment of venereal diseases that is now a standard. Whether it is possible to impose this on our members we do not know. The Association is voluntary and therefore we cannot force acceptance of this standard, but at least a clear and comprehensive statement has been made of what the effective treatment of venereal diseases in the dispensary demands in the way of treatment, medicine, dispensary appliances, equipment, follow-up treatment and so on. I believe that the Associated Clinics will accomplish its greatest useful work by applying this same method of departmental analysis to the various departments. There are problems that are specific, for instance, to the children's department, others that relate to the eye clinic.

In taking up the study of dispensary work we have tackled a huge and many-sided problem, and while it will be acknowledged much good has been accomplished by the committee of one that has reported from year to year to this Association, and while the report presented by Mr. Davis is excellent, nevertheless, the time has come when the committee should be expanded, when the scope of its work should be broadened. We should attempt to formulate a plan which will lead to the gradual standardization of dispensary work as a whole.



## THE OUT-PATIENT WORKSHOP; A NEW HOSPITAL DEPARTMENT.

BY HERBERT J. HALL, M.D.,  
Marblehead, Massachusetts.

Within a few weeks there will be ready at the Massachusetts General Hospital, a workshop for the manufacture of flower-pots. The shop will be small, but well equipped with automatic moulds, so that people of very little strength may turn out pots and flower-boxes of such design and coloring as should command a ready market at a fair price. The moulds have been so constructed as to ensure success from the mechanical and artistic points of view. Nothing will be left to the choice and initiative of the workers who will be chosen from among the chronic out-patients of the hospital—people who would otherwise be idle at home or working at some hard, unsuitable employment. This is, so far as I know, the first attempt of a general hospital to provide work that can be regulated to the capacity of its crippled out-patients, and so to protect these people from the evil effects of idleness or overwork.

No one will doubt, I think, the advantage of quiet, controlled, and fairly remunerative work for the patients whom the hospital has discharged relieved, but who are still liable to breakdown under unfavorable conditions.

The fact is, that this important element of adequate work for partly disabled patients has never been fully met by any outside charitable agency, so it is proposed that the hospital undertake to safeguard its patients and to protect itself and the public in this new way. The ability of the hospital to provide specialized and remunerative work will, no doubt, be questioned. I shall try to show the possibility of a new industrial system which shall be presided over by the hospitals, and which shall justify itself in every possible way.

Dr. Hornsby says in his report to the Board of Commissioners of Cook County: "Public institutions to take care of the sick are not wholly monuments to the

benevolence of the people; they are defensive institutions for the benefit and protection of society"; and later in the same report: "Heretofore it has been and is now the custom in eleemosynary institutions all over the world, to pick up the fallen, keep him until he can stand on his feet, and then turn him adrift. Tomorrow he falls again, and we repeat our benevolence of yesterday, and so we make no advance; and vast numbers of our poor and helpless, who could be restored to their families and to self-support are permitted to drift into a state where they become public charges. The records of our county institutions will show vast numbers of returned cases; cases that come back with the same ailments that brought them in the first place, and up to this time we have been satisfied to regard this situation with placidity." He continues his arraignment by saying: "The time has now come to take a broader, better, more businesslike view of our obligations to the poor, the needy and the helpless, if for no other reason than good business judgment." These are strong words and they mean that a great tide is turning toward better and more practical charities.

If the hospital is to undertake to improve conditions in the life of the patient after his discharge, it must begin by providing adequate work. Work with a money return must be the substantial basis of all such improvement. Without that basis—except in cases of absolute helplessness—our charity will be frightfully wasted. The Social Service workers have in the past few years accomplished a great deal in the right direction. The Social Service Committee of King's Chapel in Boston has, in Miss Harper, a woman who knows the trades and who is remarkably successful in finding work for handicapped people. But the doors of the industries are, for the most part, closed to the handicapped. Business is geared too high to give more than an occasional, subordinate place to men who are not able-bodied.

In Chicago it is proposed that the County Hospital shall control a great farm at Oak Forest, where the discharged patients shall go and where they shall remain as long as necessary under medical observation, and where they can do prescribed work for their own individual support and for the common good. Perhaps this

will be the usual and best way of dealing with the problem. I think, however, that we shall find great numbers of patients who will not do well on a farm and who must have work of another sort if they are to be controlled. Many of the people who break down and come to the hospitals would be quite out of their element in the country. They are shopworkers from first to last and they would be poor assistants on the farm although they might theoretically be better off there. Further than this, the separation of families is undesirable if it can be avoided. A great many patients unable to work in the regular industries could still live at home and work by day in specialized shops if such shops are conveniently located at the hospitals. The burden of providing work would be a much lighter one if a good proportion of the patients could have the personal care and partial support of their families.

It is easy to believe that the whole idea of specialized work is impractical. If the established factories and workshops of the world must employ only the most efficient, how can charitable institutions without experience and with crippled workers hope to accomplish adequate results? I believe that the hospital workshop—this first one in Boston and many others that may follow the example—will show the possibilities of an industrial system of tremendous economic and social importance. Not many years ago the great manufacturing plants were throwing away bi-products that are now worth their annual millions. The industrial world is today throwing away damaged human material, the reasonable salvage and exploitation of which would change the economic outlook of the world, and that would save an amount of human suffering too great to be reckoned.

An experience of ten years in the study of occupation for handicapped people of a very different class, has made me sure that this great thing can be done. The first requirement is this; that the new handicapped industries must not attempt to compete with machinery, that they must not cross the established lines. The second requirement is an assured market for all products; this implies that the choice of products shall be wise and far-seeing, and that the workmanship must be



good. The third requirement is that the work must be of a kind adapted to physical and nervous limitations.. In the light of these three requirements let us examine the flower-pot industry which is now being pursued in a small way at the Industrial Home for Convalescents at Sharon, Connecticut, and in my own experimental shops at Marblehead. If we were to attempt to make flower-pots out of clay as they have been made for generations; if our shop force of handicapped people were to compete with the jigger-wheels and the enormous kilns of the great potteries, we should not only fail, but we should amply deserve our failure. But we propose to make flower-pots in a new way—out of cement this time and cast in moulds that can be handled by a crippled girl quite as well as by a strong man. If our moulds are proportioned and designed by an artist of full ability, then the situation changes. The strong men may bend to their wheels turning out cheap and rather ugly flower-pots that sell, to be sure, by the hundred thousand. This great industry goes its way and it will not interfere in the slightest degree with the smaller, slower, but equally well justified process.

When I say well justified, I mean that this new product gives to the public at a moderate price—more expensive than terra cotta, less expensive than glazed pottery—a beautiful and useful article of common use. The material for these cement flower-pots costs from three to ten cents; the selling price is usually from fifty cents to one dollar. Thus is the second requirement fulfilled, or as nearly fulfilled as can be the case with any new idea. We are counting on the well-known market for flower-pots, and on the especial characteristics and middle priced value of our wares.

The third requirement is more easily met than most of the uninitiated would suppose possible. Here is the keynote of success for all handicapped labor. There must always be a fully trained instructor and a sufficient number of able assistants. Handicapped workers alone are hopeless and helpless; under careful direction there is no end to their possibilities. It is necessary to insist upon fractional effort. Sustained effort, without periods of rest, will end in failure for most handicapped workers. With periods of alternating work and rest, a very feeble person may accomplish, without harm, a surpris-

ing amount of work. The moulds for cement flower-pots of any shape, and for all except the larger sizes, can be handled by a person with one hand or with very defective sight or by one who, because of a cardiac dyspnoea, must work very carefully and slowly.

Cement working is but one of many possible modifications of existing industries. In the shops at Marblehead we have developed hand-weaving to a high degree of perfection. By our three requirements hand-weaving is available for convalescent or permanently limited people. We would be absolutely lost if we were to attempt to make cloth such as could be more readily made on the power looms. But by developing especial patterns and individual effects designed by clever craftsmen, we provide a business capable of supporting a great many handicapped workers. At Marblehead, we make a small woollen blanket for babies. The material costs from sixty cents to a dollar. If we were to weave a similar length and width of plain wool we could not sell it for a dollar; but because there is an attractive design and because the ends are finished well, these specialized blankets sell for six dollars. It takes about a day and a half to make one of these blankets. The factories could not take the time and trouble to produce such things, but the hospital workshops could take the time and it would mean partial self-support where such help is greatly needed.

The making of artistic pottery is a field in which handicapped labor may some day be employed. It means, however, an expensive plant and a number of expert people. My own experience in this line has been hardly less interesting because my patients have been few and of the educated class. Eight years ago we began to make pottery, thinking that it might become a good feature in the specialized industrial plan. The work did not turn out well at first because pottery making is a fine art and takes time and skill for development. We worked, of course, on a very small experimental scale, but we soon found we could not take in invalids and convalescents as helpers and apprentices because they spoiled the product. Finally the personnel narrowed itself down to four people; two workers who were pretty seriously handicapped, and two who were professional potters. These people

worked out the problem at last. The handicapped workers are now practically well and are earning a living. We have added one able-bodied worker and these five people make a successful unit. They made and sold last year six thousand dollars worth of pottery—a ware so fine that it ranks among the best in the country. Later, I shall hope to bring into this pottery business, a number of handicapped workers who will attend to various necessary details. The little plant is at present quite self-supporting.

In our shops we have tried out metal-working of the finer sorts, basketry, leather and wood carving. These crafts I have for the present discarded because we cannot make them pay. An immense amount of combined medical and industrial observation will be needed before the idea of handicapped industries can be carried out in a really adequate and comprehensive way. My own personal work has gone just far enough to make me sure we are on the right track. It has been carried out, for the most part, among people of education and means who are willing to take the Work Cure because they realize that it is the short cut back to efficiency in neurasthenia and allied conditions.

It is, of course, quite possible that the plan of the hospital workshops may not succeed in its early forms. But I hope you will watch with interest the little cement industry in Boston and at Sharon.

I believe the need is great enough and the early prospects good enough to warrant extensive experimental workshops where various trades may be tried out mechanically and studied clinically. Such a study, to be adequate, would require endowment or public support. Such support would seem well justified, for if we stop to think we shall realize that idleness means heavy tax upon the public charities and much, very much, more. From the point of view of public morals then, as well as from pressing economic reasons, the thing is justified.\*

Workshops may be established extensively in connection with hospitals and asylums in and out of the

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\*A Social Worker who knows whereof she speaks has said, "Not drink, not gambling, nor any of the other hundred vices to which the human flesh is heir, but the workless man. He is the vital problem, for he is prey to all the other evils."



cities. They may sometimes be maintained jointly by several institutions. They may be run in connection with such farms as that proposed in Chicago. They may help out materially in unexpected ways as in the problem of the tuberculosis convalescent. Until the larger development comes, we are doing the best we can without endowment, at Marblehead. These workshops are now prepared to take young men and women as pupils and to fit them, as far as possible, to direct and teach in hospitals or elsewhere. We can furnish moulds and other apparatus for cement working, looms and materials for hand-weaving.

There is nothing new in the idea of occupation for invalids. The work of patients has been successfully used in many institutions such as those for the blind and the crippled. The exploitation of handicapped labor has even been looked upon with suspicion, perhaps not always unjustified. Sometimes in homes and asylums the patients or inmates may have been employed to their own disadvantage and for the benefit of the institution.

Carefully premeditated and concerted action is needed in order that such possible injustice may cease and that a beneficent system may have its largest and finest application.

I wish that the idea might be taken up by the smaller as well as by the larger hospitals and that you may at least see your way as an association to the investigation of a matter which I know you will agree concerns to some extent the final efficiency of our hospital service.

**THURSDAY, AUGUST 28—AFTERNOON SESSION.**

**PRESIDENT:** The Convention will come to order. We will first take up the subject of Dr. Fowler's amendment to the Constitution if Dr. Fowler will be good enough to read it to the Association.

**DR. FOWLER:** The amendment that I gave notice that I would propose is to change Section 3, Article III., to be amended by adding after the word "charities," in the fifth line, the words "hospital physicians, surgeons and superintendents of nurses," and I move that that be adopted.

**PRESIDENT:** Moved and seconded that this change be made in the Constitution as read, enlarging our membership by admitting to associate membership members of the staffs of hospitals and superintendents of nurses. Is there any discussion? Are you ready for the vote? It requires a two-thirds vote to make a change in the Constitution, only active members of the Association can vote. Those in favor please rise.

The amendment was carried unanimously by a rising vote.

Next is the report of the Committee on Time and Place of Next Convention.

## REPORT OF COMMITTEE ON TIME AND PLACE OF NEXT MEETING.

To the Officers and Members of the American Hospital Association:

We, the Committee on Time and Place, have the honor to submit to you the following report on time and place of the meeting for the annual meeting, 1914. The Committee decided in favor of Baltimore, believing that the knowledge gained in hospital construction and administration will be of greater value than could be gained in the other cities considered. It was only on this account that the Committee did not name St. Paul, which city was their second choice.

Respectfully submitted,

ROBERT J. WILSON, Chairman.

ASA BACON.

MARY M. RIDDLE.

### DISCUSSION.

DR. WILSON: The Association received invitations from a number of cities pretty well distributed throughout the territory where we have the most members and we considered those cities, not taking any other into consideration. The cities sending invitations were Baltimore, St. Paul, Indianapolis, Memphis, New Orleans, Nashville, Cincinnati, Winnipeg, Buffalo, Rochester and Philadelphia. In coming to a conclusion your Committee had in mind two things, first, what the place of meeting would offer to the members, which was best fitted or best suited for their wants, and secondly, the question of increased membership in the Association, together with whatever there might be had in the way of educational or building or hospital administration, or whatever there might be in the places that we considered. I want to say at the outset that this Committee were not unanimous in the choice of a place. Two of us believe that much more might be gotten in the way of useful information by going to a city where there were high ideals in regard to hospital administration, where at least one institution was given over to the production to a certain extent of hospital superintendents. With that feeling in mind the majority of the Committee voted for the city of Baltimore, therefore your Nominating Committee stands committed to the city of Baltimore. We also considered very seriously the city of St. Paul and were unanimous in regard to the city of St. Paul if it had had what the majority of the Committee thought were equal inducements to Baltimore. I



ought to say that in considering this matter the Committee took into consideration very seriously the question of increased membership that would come to this Society from going to one of the western cities. We did not treat very seriously Indianapolis, Cincinnati, Cleveland, Buffalo, or any of the Middle West cities where there have very recently been meetings of this Association, we did not feel it was necessary. We felt that Detroit and St. Louis recently having had the meetings of the Association, it was not necessary to go into that territory again. This report, then, recommending Baltimore as the next place of meeting, is signed by the Committee, and the matter of time we thought best to leave to the Executive Committee, not knowing exactly what place would be chosen. If the city of Baltimore is selected then the time of the meeting should be, I should think—I am saying this without the other members of the Committee—I should think would be in September rather than in August as this year.

PRESIDENT: You have heard the report of the Committee, what will you do with it?

MR. OLSON: I wish to move, as a substitute to this recommendation, that we choose the city of St. Paul as the place of our next meeting. I have travelled somewhat both East and West and I tell you, ladies and gentlemen, that there is no grander spot on earth than the Mississippi Valley, and there is no better city on earth than Minneapolis, and the next is St. Paul, and the best part of it is that it lies so close to Minneapolis. I hope you will consider St. Paul. We have a university with an attendance of 5,000 students, we have a splendid new hospital in Minneapolis. In St. Paul we have one of the best municipal hospitals in the United States, I say it because it is a fact, and in Minneapolis we are building a large and elegant city hospital. We have in Minneapolis some twelve or fifteen other general hospitals and in St. Paul there are quite a number, these two cities lying so close together that they may be called one, we call them one—The Twin Cities. They are not to be overlooked because they may be lacking in interest to hospital people, they are very interesting to hospital people. I sincerely hope St. Paul will receive serious consideration. I am in favor of getting the Convention as far West as possible. I told my Indianapolis friends I would stand by them if there were no people further West asking for the Convention, but as St. Paul has been mentioned, I am for St. Paul first, last and all the time.

DR. HOWLAND: I should like to say a word as a disinterested member, not being a resident of St. Paul or Minneapolis, in favor of that as a convention city. I have recently been to the meeting of the American Medical Association at Minneapolis, near St. Paul, and I can say to the members of this Association that they have a great deal of interest there to show us. I think we would make no mistake in choosing St. Paul.

DR. ANCKER: I sincerely regret that St. Paul has but four representatives here, because the attractions in that city and

country are so great that they should be told by people who can speak better than I can. You must bear in mind that we in the great West all the time have been getting the good things that you have done to help us in building and in organizing and we have been eliminating the bad ones. And remember that the two cities of St. Paul and Minneapolis have a population of a little less than the city of Boston, we have about 600,000 people in those two cities, and we will stand second to none in attractions, as far as hospitals are concerned. The city of Minneapolis has several great institutions. The Minneapolis City Hospital has some 500 beds, the University Hospital will be one of the model hospitals of America, and I hope you will pardon my apparent modesty when I say the City and County Hospital, with its 700 beds, modern equipment, has neglected nothing to make it a great hospital, and I believe it will be well worth a journey to go there. St. Paul is a city that nature has endowed richly. There is no more beautiful country, there is no more splendid park, we have ample hotel accommodations, the journey can be made either by auto or by rail, and I know that you will find hospitable people. I am the authorized representative of the city government of St. Paul, and I have the assurance of Minneapolis and its representatives that they will join us in giving you a hearty and hospitable welcome. I am an old member of this Association, I have been thirty years in hospital work, I represent, as I say, one of the great institutions in America, I think we are entitled to some consideration at your hands and I trust your vote will be for St. Paul.

DR. KAVANAGH: As I understand, it has been the purpose of this organization to go to certain cities for the sake of creating a hospital sentiment for what we stand for in a particular center not simply to go to see magnificent ideals, but to carry our ideals there. I should like Dr. Ancker to tell us if we should go to St. Paul, if there is such a public spirit there, a public desire, or could a desire be created that would arouse the hospital managements of those twin cities and in that section round about to appreciate the coming of the Association, so that the whole territory round about will be interested in what is going on, so that when we will go out of St. Paul we shall have made the impression through that territory in favor of what we stand for. That would be an immense gain for the hospital work that we are doing if we could succeed in doing it. I would like to ask Dr. Ancker if he has reason to believe that there would be a combination of forces that would make possible this sort of success.

DR. ANCKER: I have every reason to believe that that would be the fact, I have no question about that. You must bear in mind that while the cities of St. Paul and Minneapolis have made tremendous strides in building hospitals, that the country around them that is tributary to St. Paul and Minneapolis is not yet so fully developed and the impression upon the people engaged in hospital work there would be tremendous.

DR. HURD: I only rise to say that I would be very glad indeed to have you come to Baltimore and we will do the best we can

to give you a pleasant and profitable time. From what I have heard from the speakers about Minneapolis and St. Paul I think they have perfect institutions and I do not see why they need our help at all, so that I think we will be justified in going to a city near at hand and really will see something good.

DR. ANCKER: I gathered the inspiration for the City and County Hospital from Johns Hopkins.

DR. W. H. WALSH: I came here with a very cordial invitation from the city of Philadelphia to hold their next meeting in Philadelphia. Of course it is somewhat of a disappointment to me to find that the Committee have decided on Baltimore, but knowing Baltimore as I do, I feel as though the selection is a good one, and I have reason to know that they were actuated by very good reasons in selecting that city. However, I wish to say that if the Society does not meet in Baltimore, we still extend a very cordial invitation to come to Philadelphia.

PRESIDENT: Was the motion to substitute St. Paul for the report of the Committee seconded? It has been seconded.

DR. HORNSBY: I think we ought to go to St. Paul. I, like Dr. Howland, was there recently at a convention of several thousand people and we were beautifully taken care of, as we think. But there is another phase. We were in Washington only recently, so that the great influence that we might expect from the city or the section of the country where the Convention is held must have been felt, as we have done the best we could down in the Baltimore country. We have not done anything in the far Northwest, where they are trying so hard to do things according to high ideals in hospital work, and it seems to me that we ought to recognize that great Northwest country and take to them some of the ideals of this Association if we have them and give them an impetus and inspiration, take them into the Association itself. I do not think that we ought to hold the Convention every year in one section of the country. This year we are on the Atlantic coast, do not let us hold it next year on the Atlantic coast, let us get back a little bit, let us get back to that far Northwest, that new country so inspired by its own power and so capable and receptive of instruction from others. I favor St. Paul.

PRESIDENT: It has been moved and seconded that the name of St. Paul be substituted for the name of Baltimore for the next place of meeting. Those in favor please rise. The Convention will be held in St. Paul. We will now call for the report of the Nominating Committee, Dr. Babcock, chairman.



## REPORT OF NOMINATION COMMITTEE.

DR. BABCOCK: The Nominating Committee have as well as they could in the time at their disposal sounded the sentiment of the Convention, particularly in reference to the name of the President, and beg to present these names. In reference to the Vice-Presidents I would state that last year only two were nominated, the Constitution provides for three, and in view of the possibility of further section work in the Convention the Committee thought best to nominate three Vice-Presidents. The nominations are as follows:

To the President and Members of the American Hospital Association:

Your Committee on Nominations begs leave to suggest the following members for the officers of the Association for the ensuing year:

President—Dr. Thomas Howell, Superintendent New York Hospital, New York City.

1st Vice-President—Mr. H. E. Webster, Supt., Royal Victoria Hospital, Montreal, Que.

2nd Vice-President—Miss Mary A. Baker, Supt., St. Luke's Hospital, Jacksonville, Fla.

3rd Vice-President—Miss Margaret Rogers, Supt., Jewish Hospital, St. Louis, Mo.

Secretary—Dr. H. A. Boyce, Supt., Kingston Hospital, Kingston, Ont.

Treasurer—Mr. Asa Bacon, Supt., Presbyterian Hospital, Chicago, Ill.

PRESIDENT: You have heard the report of the Committee, what will you do with it?

DR. KAVANAGH: In spite of the fact that this nomination has come through a committee, the report is a very good one, and I will move that the Secretary cast the ballot for these nominees as read.

The motion was seconded and carried unanimously by a rising vote.

DR. GOLDWATER: If I am in order, I have a resolution to present. I wish to offer the following resolution: In view of the growth of the Association and the change in character of the membership of the Association which has taken place since the Constitution and By-laws were adopted in their present form, that the Committee on Constitutions and By-laws for the ensuing

year be and hereby is instructed to prepare a revised Constitution and By-laws and especially to consider the desirability of providing for the appointment of a paid secretary.

The resolution was seconded and adopted unanimously by a rising vote.

DR. HURD: I have a resolution which I desire to offer. It refers to the paper largely of Dr. Hornsby in reference to approving the measures which have been proposed in other associations to provide for the inspection and classification and standardization of hospitals. You will notice that this resolution is restricted in its scope, because it seemed to me rather desirable, as the class is such a large one, that we should take up only a small portion of it at this time.

Dr. Hurd offered the following resolution for the Inspection, Classification and Standardization of Hospitals, which was unanimously adopted:

*Whereas*, The American Medical Association through its Hospital Section has expressed its approval of the advisability and desirability of classifying and standardizing the larger hospitals of the country to ascertain their fitness to furnish proper clinical facilities for physicians and nurses; therefore be it resolved

1. That the American Hospital Association cordially approves of the measure as one calculated to greatly increase the efficiency of these hospitals and to improve and standardize their work.

2. That the American Hospital Association hereby authorizes the appointment of a Committee of three persons to consult with a similar committee of the Hospital Section of the American Medical Association and co-operate with it in promoting the measure.

DR. HURD: Mr. President, I wish to move the adoption of these resolutions.

PRESIDENT: Moved and seconded that the resolution just read by Dr. Hurd be adopted. Is there any discussion? If not, those in favor will signify by saying aye, opposed no. Carried.

How do you wish that Committee to be appointed?

DR. HURD: By the President.

PRESIDENT: The Committee will be appointed by the incoming President.

## THE FUNCTION OF THE HOSPITAL IN PREVENTIVE MEDICINE.

BY DR. HENRY S. MATTHEWSON,

Surgeon, United States Public Health Service, Portland  
Quarantine Station, Portland, Maine.

The history of hospital development in the United States is of great interest when viewed from the increase in function which has taken place in the past one hundred and fifty years. Some years before the Revolutionary War, hospitals were established in New York and Philadelphia, simply for the care of those who were sick or injured. A few years later insane patients were cared for on the ground that they were ill and needed hospital treatment; rather than confinement in jail or prison as incorrigible. Early in hospital development we see the field of the hospital as a place for the education of young medical men gaining recognition. At the foundation of the Massachusetts General Hospital here in Boston nearly a century ago, provision was made for a certain number of house pupils, thus clearly recognizing the teaching function of the hospital. Well within the memory of most of us our hospitals awoke to the fact that trained nurses could not be had without schools in which training could be secured. Hence followed the establishment in the hospitals of schools for the training of nurses.

The past thirty years has seen the gradual development of pathological and bacteriological laboratories in connection with our larger hospitals. The end sought, however, was the furnishing of aids to diagnosis to the attending staff and only indirectly was any benefit to the patient involved. The careful preservation and indexing of case records so largely developed within the past few years may also be mentioned as rounding out the full stature of the ideal to date, in hospital development.

At present, then, we find the modern hospital a highly specialized institution. It is fully equipped to treat all classes of patients and neglects no means known to science to rapidly effect a cure and to return the patient to active life, able to cope with its problems.



But is this enough? Has the hospital then discharged in full measure its duty to its patients? I believe not.

The world has been dominated for centuries by the theological idea that disease and injury are divinely appointed agencies. They are supposed to operate either as a punishment for man's sins or as a disciplinary measure to fit him to wear a crown and twang a harp in a better world. What, then, could the hospital do but receive the sufferer, mitigate to what extent it could the severity of his sentence and discharge him with the injunction to return again when necessary. The introduction of vaccination against smallpox was not a little impeded in this country by thunders from hundreds of New England pulpits against such impious interference with the decrees of an offended God. We are just beginning to suspect that such ideas may not be entirely true. Any large city expends annually at the present time millions in combating disease, crime and fire. How much is expended in prevention? Comparatively little. Yet a beginning has been made and in that beginning lies the hope of better things.

More than twenty-five years ago the State of Massachusetts established the first sanatorium for consumptives and in so doing has the honor of being the pioneer in the world-wide war against that disease. Incipient cases only were accepted for treatment. It was found, however, after years of experience that there was no diminution in the number of early cases applying for treatment. New cases of tuberculosis were constantly furnished by the contagion spread abroad by the late and chronic cases refused sanitarium treatment as unsuitable in that no hope of a cure could be entertained. An experience of three years in sanatorium work has convinced me that the most promising line of attack lies in the compulsory segregation of the ignorant and careless consumptive and in the education and supervision of the intelligent consumptives, and thus preventing infection of new subjects.

What is true in the case of tuberculosis may also be true in the case of many general systematic and local diseases. This field for investigation is a large one and we turn with confidence to the hospitals of this country for its exploitation. Why should not the general and special hospital take part in a campaign for

the prevention of all classes of disease? You have the plant necessary. You have cases in large numbers and you have all the time between now and the end of the world. Institutions may and do survive for centuries, while the individual investigator has but a few years in which to work.

There are many lines along which the general hospital might work and in so doing become an important factor in the great work of Preventive Medicine. Three suggest themselves for emphasis here and in at least two of the three, a tentative beginning has been made in many hospitals. I have in mind laboratory research, intensive study of carefully taken case records, and the education and re-education of the patient.

As to the first of these, a little research work has been done, in connection with routine ward work, by some of our hospitals for many years. This work, however, needs direction and intensification. This Association might well take this matter up and plan among its members a combined assault upon some problem in Preventive Medicine. At present too much desultory work is done, which leads nowhere and is productive of results of no value. The general hospital has an opportunity in research open to none other in the study of the rarer forms of disease and this too should not be neglected. When the cause of a certain disease has been discovered and the pathology of the disease has been worked up, many investigators consider that problem solved, but in reality only a beginning has been made. A patient dead from pneumonia is little benefited by the knowledge that the pneumococcus has killed him by causing a purulent exudate into the air cells of his lungs. Let us go back of all that and try to discover the condition under which the organism develops outside the body, in what manner it gains access to the body and what conditions favor its development therein. Then, and only then, can measures be devised to protect ourselves from the attacks of this great destroyer.

Laboratory research work has furnished us with many unanswered questions. Among the most interesting of these are the variations in the action of disease causing organisms in different cases. An answer

to this problem may be found in some factor to be discovered in the life history of the patient.

Case histories as at present taken in most of our hospitals are practically worthless. They are taken by a junior member of the house staff in a hurried and perfunctory manner. There is no competent supervision of his work and the case history often has no earthly relation to the diagnosis found at the head of the history sheet. Would it not be practicable to appoint a histographer upon the Staffs of the larger hospitals at least, whose duty it should be to supervise all case records? Proper instruction in history taking could be given the House Staff and assistance in filing and the making of references could be furnished the staff in the records room. A primary requisite for making these records available for study is that they are accessible, accurate and aggregated in large numbers. Whenever a large number of histories of a certain disease become available, research workers could be detailed to study these records, in search of the common factors having an apparent connection with the production of the disease in question or having a bearing upon the treatment of the same. Many facts of important bearing upon the etiology and incidence of disease doubtless lie buried in the records of our hospitals.

In 1894 Dr. R. F. Weir, of New York, performed at the New York Hospital the first operation for the relief of the condition known as surgical kidney. The patient recovered and this hitherto fatal disease became amenable to treatment. A search of the autopsy records of the hospital made at that time by Dr. Weir's surgical staff showed a considerable number of cases of surgical kidney which had come to autopsy in the preceding one hundred years, in which the condition was unilateral. These cases were operable. Had this been known why should not this operation have been done many years earlier?

Recent investigations in the causation of beri-beri have shown that the long sought bacterial cause does not exist, but that the disease occurs in those who eat largely of polished rice. A rapid cure is effected in those suffering from this disease by injection of an extract made from rice polishings. Incidents could be multiplied where the clue to the solution of problems



in preventive medicine have been found in the case histories of a large number of patients of a given disease and work along that line is most promising.

#### EDUCATION AND RE-EDUCATION OF PATIENT.

The hospital of late years has come to stand in the place of the family physician to many of its patients that is to say many of its beneficiaries have no family physician. The need therefore for the hospital to assume the functions of a family physician is apparent. This function cannot, for mere lack of time, be discharged by the attending physician or surgeon, who has or may have, anywhere from thirty to one hundred and fifty patients in his wards. It is a physical impossibility for him to discuss with each patient in his charge the factors having a causative influence in the production of the condition he is called upon to treat. Why should not the hospital take up the education of its patients as a factor possibly of importance in preventive medicine? Many thousand persons pass annually a considerable time in our hospitals. Many of them are intensely interested in their conditions and are lamentably ignorant of the fundamentals of right living. At present we treat, for example, cases of broken compensation in heart disease or an acute exacerbation in kidney disease. The patient is discharged "improved." We expect him to come back and he does come back, often time and time again. Why should he not receive explicit instructions as to how to avoid a recurrence of his frequent breakdowns. Sanatoria for the care of consumptives have made a beginning in this work. By means of printed matter, verbal instructions and lectures to groups of patients, we instruct them as to dangers of infection and reinfection, as to safe methods of the disposal of sputa and excreta, as to diet and mode of life, clothing, fresh air and exercise and the many things which have been found to be of importance in the cure of consumption. Why should not this be taken up by our general hospitals and extended to cover many classes of disease?

In the last decade there has been an alarming increase in the incidence of the group of the so-called degenerative diseases of middle life. The expectation of life of a man of forty-five is actually less today than

it was ten years ago and this in despite of the great advances made in the control of many diseases. The causative factors in the increase in degenerative diseases must be sought in the histories of a large series of such cases and instructions formulated as to how the individual may escape the results of his own ignorance or folly. I know of no agency which can so well perform this service to the race as the general hospital. For many years it has been my custom to furnish certain intelligent medical cases upon leaving the hospital with typewritten instructions as to diet, mode of life, etc., the observance of which might tend to prevent a recurrence of their illness. This procedure I believe to be of distinct value in cases of diabetes, Brights disease, cirrhosis of the liver and heart disease.

In any large hospital there may be observed any day a considerable number of patients upon whose hands time seems to hang a bit heavily. Would it not be practicable to demonstrate to these in small groups, something of the methods employed in the hospital for the prevention of the transfer of infection from one patient to another, for the disinfection of excreta, bedding and dressings, the methods of preparing foods, of ventilation, etc. This could be supplemented by lectures on suitable hygienic topics and by printed matter bearing on the special disease from which the patient was suffering, and on the general requisites for "a sane mind in a sound body."

The United States General Health Service at present is printing for general distribution monographs upon subjects connected with the health of the public. These are brief, worded so as to be understood by any reader and are calculated to give the public definite information upon a certain subject of importance in connection with health matters. These may be secured by application to the Surgeon General, United States Public Health Service, Washington, D.C. The Health Boards of many states furnish printed matter of this nature for general distribution, and which may be obtained by institutions in the individual state. Thus it appears that printed matter is available from various sources. Sporadic attempts to educate the public have always been made. The story is told of Erasmus Darwin, grandfather of the great naturalist, that he, hav-

ing dined not wisely but too well, was discovered a short time thereafter mounted upon an overturned tub in the market place of Nottingham, haranging the public as follows: "Ye men of Nottingham listen to me. Air becomes unwholesome in a few hours if the windows are shut. Open those of your sleeping rooms whenever you quit them to go to your workshops. Keep the windows of your workshops open whenever the weather is not insupportably cold. I have no interest in giving you this advice." This was said in the eighteenth century but it has not as yet reached the major part of our population.

Preventive medicine may not be to our interest, but the welfare of our patients is and ever should be our paramount interest. I confidently believe therefore that the hospitals of this country will take an increasingly important part in the grand attack that is being made upon the agencies, visible and invisible, which wage so relentless and unceasing a war upon the human race.

#### DISCUSSION.

MR. R. P. BORDEN: I have been a little bit disappointed at these various conferences that there has been such a lack of discussion of the papers, and one of the chief values of the conference is the criticisms that can be made when the papers are read. Were it not for that we might as well stay at home and read the papers at our leisure. I am very well aware that some of us have more courage than discretion and therefore talk a little too much. The only trouble is that most of you have more discretion than courage and do not talk enough.

With regard to the duty of hospitals in preventive action, it seems to me a very important duty of the hospital, so far as the keeping of the records is concerned, that it is the duty of the Staff, rather than the duty of the trustees and of the superintendents to make the histories complete. If the members of the staff insist upon having sufficient stationery furnished them to make very complete records, I think that that is about all the hospitals and institutions can do, but it occurs to me that there are practical ways in which the hospital may interest itself in preventive medicine. In the first place, it ought to get hold of the disease before it comes to the point where hospital interference is necessary, and we are trying to do that in a small way in the town in which I live. The hospital employs the superintendent of the Visiting Nurses' Association. The superintendent of the Visiting Nurses' Association is also the superintendent of the Seaside Home. The Settlement House is also a branch of the Visiting Nurses' Association. The object of all



that is to have these people, these agencies, discover at the earliest possible moment the outcome of the disease, to give such treatment as is necessary and such instruction as is necessary to prevent the further inroads, if it can be done outside of the hospital. If hospital interference is necessary to bring these people into the hospital at the earliest possible moment and thereby prevent the long stay and the possibly inefficient work of the hospital due to the patient coming to the hospital only after the disease is advanced so far as to be pretty nearly incurable.

DR. EDWARD M. BRUSH (Baltimore): It may be of interest to the members to know that the first petition in regard to a hospital presented to a legislature in America asks for a hospital where the insane sick can be cared for. "Many lunatics who are languishing in jail, deprived of the care they ought to have." (Reads). I say it is of interest in connection with this, and the ideas which have been presented in this paper, that for a long time the hospitals for insane in this country, in New York particularly, have been doing exactly this work in the after-care of their patients. After-care associations have been formed, patients were followed up, not only that, but their accommodations sought for, their environment is sought for and changed if necessary. In the hospital with which I am connected we are in the habit of following up our patients at least once a year. When I came away the other day I left my stenographer looking over a package of seven or eight hundred letters that patients had been writing, and I have been writing them again, giving them counsel or courage or whatever may be necessary. Those patients, many of them, are looking after the members of their own family. The other day a young woman came to me who was a recovered patient who four or five years ago was in danger of breaking down again and I found that the occupation that she was following was the cause of her breakdown, it was occupational disease and through the social service of the Johns Hopkins Hospital I found some other occupation for her in different surroundings, more agreeable work, and she continues well. She came to me, not for herself the second time, but for her sister, who was breaking down with tuberculosis and I found a country home for her sister. So that I think in view of the fact that the first hospital founded for the care of the sick had in its inception the desire and intent of caring for the insane is rather interesting and that this after-care work has been taken up in general hospitals and by hospitals for mental cases.

DR. G. A. BLUMER (Butler Hospital, Providence, R.I.): Mr. President, Ladies and Gentlemen: In order that the inference may not be drawn from the concluding words of Dr. Matthewson's paper that to acquire wisdom in the matter of good ventilation it is necessary that one should as a preliminary measure get full, I should like to call his attention and the attention of the members of this Association, to a very wise remark made in 1870, by one of Dr. Matthewson's own countrymen, namely, Benjamin Franklin. I have in my possession an old magazine

called *The Columbian Magazine*, which was published in Philadelphia in 1786, and in that volume is a paper by Benjamin Franklin on the art of procuring pleasant dreams, written by request to a young lady in Philadelphia. In the course of that article Benjamin Franklin says, as nearly as I remember his very words: "It is recorded of Methusaleh, who having lived to be 787 years old, may be presumed to have lived his life along lines of most perfect hygiene, that when he was 500 years old an angel appeared unto him and said: 'Arise, Methusaleh, and build thee a house and thou shalt yet live 500 years longer.' Methusaleh said: 'If I am to live but 500 years longer it is not worth while, so I shall continue to sleep in the open air, as I have heretofore.'" Therefore, Benjamin Franklin goes on to say, that physicians have already discovered or are beginning to discover that fresh air is a good thing for those who are sick, and presently it will be found that it is also a good thing for people who are well and that people are getting over their *airephobia*, as Franklin said, and that they will let down the windows of their chambers and let down the glass of their carriages.

PRESIDENT: The members of this Association who were in Toronto will remember Dr. Mackintosh. I wrote Dr. Mackintosh and asked him to tell us something of the effects upon the hospitals of Great Britain and the medical profession, of the National Insurance Act. He has very kindly complied. He is not here in person and Dr. Boyce will read his paper for him.

## NATIONAL INSURANCE IN GERMANY AND ENGLAND.

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NATIONAL INSURANCE IN GERMANY.

In Germany the control of medical benefit is in the hands of the societies, and there are no intermediate bodies. Conditions of service and matters relating to control are arranged directly between the medical practitioners and the society.

It often happens that the doctors in a district are combined together in a federation, and the societies will combine together in a similar federation; terms will then be arranged between the two associations. It is obligatory on the societies to provide medical benefit. If they do not, appeal can be made to a supervisory authority which intervenes and makes arrangements with the medical practitioners, which are binding upon the society. In certain exceptional cases, where it is impossible to arrange medical treatment, money benefit, not exceeding two-thirds of the ordinary benefit, may be given.

There has been a bitter controversy between the medical profession and the societies for years, and it has received a stimulus recently from the increase in the wage limit from £100 to £125 per annum. The full aim of the medical profession has been to have unrestricted free choice. Against this the ideal of the society has been to have no choice, but that in each district the insured persons must go to one doctor. It is not perhaps too much to say that unrestricted free choice of doctor has its disadvantages in the excessive strain it places upon the funds of the society. Similarly where an insured person has no choice the outlook for the medical profession is bad, especially for the younger members who are just entering upon their professional duties. In certain places an agreement has been arrived at between the two systems of allowing free choice from a number of doctors appointed by the society. Freedom of choice has been an important factor in forcing up the remuneration of the medical



profession, because there are invariably more doctors than are required, with the result that all endeavor to obtain payment of a sum which will give them a living remuneration. Under a monopoly of service a few people draw large sums and farm out to younger practitioners. A large number of societies have conceded free choice among an association of doctors where such a body has been organized. An important group of societies is that federated under the title of the Leipzig Sickness Funds. This Society makes agreements with the medical practitioners, who have formed two official associations which include all the practising doctors within their areas. Any doctor belonging to either of those associations can make a contract with the society to give medical attendance, and the members of the society have a freedom of choice from doctors who have entered into these contracts. This arrangement very largely approaches the system in England with certain differences which will be manifested later, when the English system is described.

Disputes between the doctors and the society have to be determined by the Arbitration Committee. The appointment of this Committee, which acts as a conciliation committee, was the result of a long and bitter controversy. The Society had for a long time given choice to their members of a large number of doctors, having in 1904 agreements with 233 doctors to provide medical treatment at 4/6 per member per annum, for which sum dependants of members also had to be treated. Naturally the doctors demanded higher rates of pay; the rates they asked for were 4/- per member without dependants and 12/- per member with dependants. In reply the Society offered a capitation payment of 5/6 per member. An additional demand on the part of the doctors was that in the future payment of medical service should be arranged between the Society and the Medical Association, and that agreements with individual doctors should not be terminated at the will of the Society. Negotiations did not produce any result, and on April 1st, 1904, the doctors declined to come to terms. The Society adopted the only measures which were open to them, as practically all the doctors in Leipzig and neighborhood supported the profession, by importing doctors from other centres. These methods

were not successful. On petition being made to the supervisory authority to compel the Society to provide the medical benefit which was obligatory under the law, that body decided that 112 doctors were necessary to give efficient medical service, and, as the Society was unable to obtain this number, the supervisory authority entered into contract with the organized doctors under the following terms:

1. There should be free choice of doctor.
2. 5/- per member without dependants, 3/- per person entitled with benefit to dependants, and 3/- per dependant.

A counter-balancing provision was made that if the total expenditure of the Society on money benefit and medical and surgical appliances exceeded a certain sum the excess was to be deducted from the sums available for the medical service.

The agreements entered into with the doctors who had been imported were to remain firm, but were to be terminated at the earliest possible moment. An important feature of the agreement was the provision for the establishment of committees for controlling the doctors and for settling disputes. The Society as a last resort removed medical treatment to dependants from the list of benefits, thereby reducing the amount payable in capitation fees to the doctors.

Matters continued hostile for some time between the organized doctors and the imported doctors. Ultimately, in May, 1905, the Society and the organized doctors came to terms and agreed to those fixed by the supervisory authority, except that where there were dependants entitled to medical treatment the capitation fee should be somewhat lower. This agreement in 1910 was renewed for six years, providing for an increase in remuneration.

A conflict also occurred at Cologne, where the sickness societies had employed district medical officers, leaving their members no choice, but gradually free choice among a small number of doctors had been conceded. At first the doctors appeared to be in the ascendant, as the supervisory authority fixed the terms of an agreement over the heads of the Societies. The Societies, however, were able to satisfy the

requirements of the supervisory authority by showing that they had a sufficient number of doctors to give service.

The reason which prompted that step was the enormous increase to an average society in the cost of various services. For instance, a medical service which in 1903 cost 2/11, in 1906 cost 5/2 and in 1908, 8/3. Similarly money benefit had increased from 11/- per member in 1903 to 14/9 per member in 1908. In 1909 fresh arrangements were made, and there has been a considerable drop subsequently in the expenditure to the society. The doctors have gained something in the struggle with the extension of the principle of free choice of a doctor and also an increase of remuneration, although a considerable portion goes to the imported doctors. But the enormous increase in the expenses of which I have just given an illustration, where the doctors were more or less uncontrolled, has also had its effect upon public opinion. There must be such a thing as free choice, and the medical profession can always demand with proper organization a fair remuneration and probably be successful, but if they are reckless in giving certificates for incapacity for work, and in their demands for remuneration, the effect must be to bankrupt the society which is the source of the remuneration.

I have gone into this matter at some length because the question of control in England depends upon the way the medical practitioners act. At present there is an agitation, which may increase unless doctors are more careful with medical certificates, for the appointment of State medical referees, but it has not yet reached important dimensions. There is also an agitation by friendly societies that the control of medical benefit should be placed in their hands. I do not suppose that if a service is given by the English medical practitioners which does not imperil the stability of the societies, that the question will arise.

Various other methods are adopted in Germany as to the control of the medical service. The members of the Leipzig Sickness Society have free choice of doctor, and the doctors are controlled through an association of their own. Any complaints are made by the society to the association and the latter investigate the matter.



The society has power to fine a doctor for giving an improper certificate, etc.

At Munich there is a somewhat similar arrangement, but separate committees of doctors control charges, prescriptions and certifying of patients as incapacitated from work. Many of the societies have doctors acting as confidential advisers who examine patients suspected of malingering, and who are consulted when there is a doubt whether an insured person should be sent to a hospital or not, as in Germany the society has to pay a *certain sum when their members are treated in hospitals*. The societies consider the use of these officials justified because where there is free choice of doctor there will be considerable variation among the medical practitioners as to what constitutes total incapacity. They also perform a useful service, because where a doctor is in doubt on a particular case he can always refer the matter to the confidential adviser.

The following particulars for 1910 of the work of the two confidential advisers of the Leipzig District Society make very interesting reading, and it will be seen that the confidential advisers send a large number of persons off the funds of the Society.

#### LEIPZIG DISTRICT SICKNESS SOCIETY.

8,497 requests were made for visits to patients to ascertain whether they were genuinely unable to work.

3,382 of the requests were made by treating doctors.

2,494 of the requests were made by the head office of the society.

2,399 of the requests were made by the supervisors.

222 of the requests were made by the visitors.

Of the 8,497 patients—

111 were excused.

1,259 did not come for examination.

1,300 notified recovery before examination.

As regards the 5,827 examinations made—

47 per cent. of the patients were declared able to work forthwith.

12 per cent. of the patients were declared able to work at the end of the week.

10 per cent. of the patients were to be re-examined at the end of one or two weeks.

31 per cent. of the patients were declared unable to work.

4,218 cases were reported for visiting to decide whether the patients should be sent to a cure establishment or a convalescent home, or for a stay in the country.

582 patients did not appear for examination.

3,636 patients were examined.

625 cases were reported for examination as to whether special medical or surgical requirements should be given.

108 patients did not appear for examination.

517 patients were examined.

1,735 persons were examined who applied for voluntary membership of the society.

Complementary to control is the arrangement between societies and doctors for discussing matters of policy. The Leipzig has an excellent system of a conciliation committee which consists of three representatives of the doctors. That committee discusses matters of common interest and settles disputes. There is also an arbitration committee which consists of three representatives of the society and three doctors and in addition three Local Government officials. One of these officials is the chairman, and the committee acts as a final court of appeal for settling disputes. There are conciliation committees on similar lines, with slight variations as to appointment of chairman, existing in various parts of the Kingdom.

As to remuneration of the medical profession in Germany, most of the large societies pay a capitation fee of so much per member. In some places, such as Leipzig, the whole of the money available for medical service is handed over to the medical associations, and they in turn distribute it among their members in proportion to the amount that would have been received had an insured person been attended as a private patient. The tariff is drawn up as to the charges for various services performed by the doctor, and the doctor receives either payment of his account in full, or if the amount of money available is not sufficient then he receives a *pro rata* amount.

Arrangements on similar lines are made at Munich and Frankfurt-on-Maine, but in the last-named the doctor is not allowed to commence his services until six months have elapsed since he made his application, and during the first three months he has to attend various meetings, generally to make himself familiar with his work.

Where the members have not free choice of doctor and whole time service prevails, there the doctor is remunerated by a fixed salary or on some percentage basis.

The Kiel District Society gives some figures as to the income received by the 34 doctors having agreements with that Society. One doctor received over £600, two doctors received between £500 and £550, two between £300 and £400, nine between £200 and £300, eight between £100 and £200, and twelve under £100: the average works out at a remuneration of £200 per annum.

The following facts as to capitation fee per member paid to medical practitioners by the Leipzig District Society are interesting:

3/-	to the end of 1887, attendance on dependants included.
3/3½	from 1st Jan., 1888, attendance on dependants included.
3/7¼	from 1st Oct., 1888, attendance on dependants included.
3/10¾	from 1st July, 1896, attendance on dependants included.
4/2½	from 1st Oct., 1897, attendance on dependants included.
4/6	from 1st Oct., 1898, attendance on dependants included.
5/-	from 7th May, 1904, without attendance on dependants.
6/6	from 1st May, 1905, attendance on dependants included.
7/3	from 1st Jan., 1911, attendance on dependants included.
7/6	from 1st Jan., 1912, attendance on dependants included.

For a member without dependants the capitation fee is still 5/.

The present agreement is in force until 1916.

The payment by the same society for various treatments in the year 1910 were as follows:

Total amount paid ..... £74,531

This amount included—

Capitation payments .....	£56,101
Special fees to the society doctors .....	3,660
Payments to practising doctors employed at salaries (under old contracts) .....	551
Payment to society doctors outside the district .....	4,215
Payments to doctors other than society doctors .....	1,719
Payments to polyclinics .....	1,329
Payments to dental surgeons .....	4,861
Payments for massage treatment .....	396
Payments to Zander Institute (for Röntgen Ray treatment, etc.) .....	314
Payments to doctors in respect of other expenses .....	212
Repaid to members in respect of payments made by them for medical treatment....	410
Payments to the confidential medical advisers .....	763

The following table for the year 1910 shows the extent which the treatments of the dependants affects the work of medical practitioners:



Free medical treatment was given to

Members..... 76,572 cases of members who were unable to follow their employment.

212,377 cases of members who were able to follow their employment.

140,021 male members.

72,856 female members.

Total..... 289,449

Dependants of members, 248,760 { 79,235 wives.  
161,948 children.  
7,577 other dependants.

It will not be surprising therefore that there have been strenuous demands for an increase of rates. This, as I mentioned at the beginning, has been partly affected by the large increase of newly qualified doctors. In 1885 there was one doctor to 3,000 persons, whereas now there is one doctor to 2,000 persons.

Drugs are not dispensed by the doctor but by pharmacists, who in Germany have a virtual monopoly, as it is difficult to obtain a license by the public authority to trade. Prices, however, are officially fixed, so they can not charge any prices they desire, but the official tariffs leave them a liberal margin. They have, however, only a monopoly of the sale of certain medical and surgical appliances, and, in the various articles to which their monopoly does not extend, there is keen competition by druggists. As a rule the pharmacists allow members of societies certain discounts from about 10 to 25 per cent. Under the new law of 1909 it is provided that a discount must be given to sickness societies and the authorities are to decide the amount of discount. The prescriptions by the doctors and also the charges of the pharmacists are carefully checked by the societies, and in some cases the societies combine to check the number of certificates given by a doctor to see whether he is too free in certifying inability to work. The expenditure on medical and surgical requirements is very large and averages about 4/- or 5/- a year but this includes such things as special baths, etc. The societies state that the extension of freedom of choice of doctor is one of the causes of the increase of expenditure on drugs. One other point has been commented upon by a German doctor who has had considerable experience in insurance work, that where an ordinary person is content to be told that he can be cured without recourse to drugs, the insured person is not content unless he is

given a bottle of medicine. It has been mentioned in England that the Insurance Act would have a great effect of reducing the sales of patent medicines. This may prove to be so, but 25 years' experience has not shown it to be the case in Germany.

The following details of expenditure of medical and surgical appliances in the Leipzig District Society and, secondly, in the Munich District Society, are interesting:

#### LEIPZIG DISTRICT SOCIETY.

£31,488 was expended on ordinary medical requirements, including wine and dressings.

£8,512 was expended in addition on special requirements.

The items included in this £8,512 were:—

£4,389 for baths.

1,274 for spectacles, &c.

1,246 for trusses, &c.

621 in contributions towards cost of artificial teeth.

477 for milk.

341 for electrical treatment.

146 repaid to members.

14 for artificial eyes

4 for ice.

The drugs, &c., were ordered in 773,333 prescriptions, each prescription representing, on the average, a cost of 1/0¼.

#### MUNICH DISTRICT SOCIETY.

£20,017 was paid to the Munich Association of Pharmacists.

1 " " to various Munich Pharmacists.

218 " " to Pharmacists outside Munich.

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£20,236

£1,150 " " for trusses, flat-foot appliances, &c.

768 " " for spectacles, &c.

23 " " for artificial eyes.

1,501 " " for baths.

523 " " in contribution towards cost of artificial teeth.

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3,965

280 " " to various clinics, &c., in payment for dressings.

£150 " " for the checking of prescriptions by doctors.

218 " " for the checking of prescriptions by pharmacists.

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368

5 " " in respect of the confidential advisers' department.

1 " " in respect of the department of the society for medical requirements.

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£24,855 Total.

The figures of the total average expenditure for the Cologne District Society for various employees are also interesting as showing the average expenditure per member on medical and surgical requirements and sickness benefits, because it shows the increase that the societies contend is brought about by free choice of doctor. The figures from 1903-08, when the relations between the doctors and the societies were strained, are very instructive.

	S.	D.
1903 .....	27	6
1906 .....	32	9
1908 .....	37	0
1910 .....	33	3

#### NATIONAL INSURANCE IN ENGLAND.

In England, Scotland and Wales, medical benefit is not administered by the approved societies, but by 238 Insurance Committees, which are semi-public bodies numbering not less than 40 or more than 80, according to the population in their area. Three-fifths of the number are appointed by members of approved societies, one-fifth by the County Council; two members are elected by an association of duly qualified practitioners resident in the county; one to three members, according to the size of the Committee, must be duly qualified medical practitioners appointed by the County Council, and the remaining member shall be appointed by the Insurance Commissioners.

These Committees issued invitations at the commencement of this year to all the medical practitioners within their areas to join what was known as a panel of doctors. In most places where the panel system exists, payment by capitation prevails. In one or two places, however, payment is made by attendance according to a fixed scale of charges, but this arrangement is not liked by the approved societies, for should the total charges by the doctors exceed the amount available for the medical service for that area they shall be paid a *pro rata* amount; therefore, the doctor who presents the largest bill receives the greater payment, and this is a temptation to a doctor to run up charges unnecessarily.

The experience of one or two of the big societies has been that where the system of payment by attend-



ance prevails they have had very heavy sickness claims. It is not possible at this early date to say whether the charges made against the system of payment by attendance will be borne out, because during the first three months of the operation of medical benefit doctors have had an enormous amount of clerical work in connection with their patients and the state of affairs has been somewhat abnormal. The doctors on the panel receive a remuneration under the capitation system of 6/6 per head as capitation fee, 6d. per head for the domiciliary treatment of tuberculous cases, and what is available at the end of the year of what is known as the "floating 6d." This last amount is dependent upon the amount of drugs used. An allowance of 1/6 per head per insured person per annum is available for drugs; this is not paid to chemists by way of capitation, but they are reimbursed up to this amount. So as to induce doctors not to be extravagant in ordering drugs it is provided that the chemists, should their total bills exceed the total number of eightpences available, can draw up to a further 6d. per head. If, however, they do not draw the 6d. or only a part, the whole of the 6d. or the balance is paid to the doctor. In a neighbourhood where the doctors are careful they can receive a total capitation fee of 7/6 per person. Special payments are made for mileage in sparsely populated districts.

The panel system is in operation in England, Scotland and Wales and seems to be working satisfactorily. In certain places some doctors have an abnormal number of patients, but it is hoped that this will prove to be temporary. The formation of the panel system has brought out that in certain working class areas there has not been an adequate supply of doctors to give proper medical attendance in the past, on account of the difficulty of receiving payment for services rendered. Now a very promising field is opened up for doctors just leaving the hospitals. There was a sharp and bitter controversy about medical service in England, but the doctors, by the solidarity of their organization, gained a great advance on the terms that were originally offered them. In the original Bill provision was made for a capitation allowance of 6/- per person, out of which had to come 1/6 for drugs, leaving the doctor

4/6. It was argued that doctors had been doing club work in the past at rates varying from as low as 2/6 per person to an average of 4/- to 4/6 a year. The doctors retorted that the old club members were usually picked lives and that under the present Bill they would have a greatly increased amount of work to do. As a result of the doctors' agitation the provisions of the Bill were considerably altered. Doctors who had been doing club work under the control of the friendly societies had no wish to have dealings with the approved societies who would take the place of the friendly societies. This point was conceded and the dealings were to be with the Insurance Committees.

Free choice of doctor was also granted. Perhaps I should qualify this statement by saying that there is still a controversy raging as to what was promised by free choice of doctor. Some of the doctors say that it meant that the insured person could go to any doctor, and if the doctor he wanted to go to was not on the panel he could make his own arrangements and receive a contribution towards the cost of his treatment. Free choice is limited to the doctors on the panel and as there may be any number up to about 1,000 according to the population of the area, it will be seen that the insured person has a fairly wide choice.

In England the approved societies do not have to bear the whole of the cost of medical benefit. Six shillings and sixpence altogether comes from the approved society, of which the State hands back to the approved society two-ninths in the case of men, one-fourth in the case of women; the rest is found by the Treasury, i.e., from the ordinary finances of the country. The doctors seem content with their remuneration and probably their yearly income will be found to be about £300, with a general average of £300 to £350 per annum. In certain exceptional circumstances doctors are allowed to dispense their own drugs.

The question of control has not arisen in England and the question whether it will arise depends upon how the doctors administer the Act. I went into this question at some length before and showed that in Germany it was the increased cost of medical services which raised this question in an acute form. So far conditions in England have been abnormal. During the first three

or four months of the Act the effects of the controversy were gradually dying down. For about six months before the medical benefit came into operation the doctors had been making remarks about the treatment they had experienced under the Friendly Societies, which were not at all complimentary, and the Friendly Societies were agitating for "whole-time" medical service, but both parties have realized that there is more to be gained by co-operation and better feeling is now prevailing.

Machinery for control is provided by the appointment of local medical committees and if the Insurance Commissioners are satisfied that such a committee is representative of the duly qualified medical practitioners resident in that area they are then required by the Act to recognize that body and the Insurance Committee has to consult with it on all general questions affecting the administration of medical benefit. A point of difference between the German arrangements and the English arrangements is that under medical benefit in England only treatment within the competence of an ordinary medical practitioner is given whereas in Germany payments are made to specialists. Treatment is not at present given to dependants of insured persons, but power to extend the medical treatment to dependants is an additional benefit which may be given later. The necessity of this extension is being very strongly emphasized at present. Dental treatment is not given, but power is also given to the approved society to pay the whole or any part of the cost. These extensions are known as additional benefits. It is unlikely that any extension will be made before the first valuation when societies will know their financial position.

Power is given also to the Insurance Committees to allow persons to contract out; that is, to receive treatment from a doctor not on the panel, but, as the matter of contracting out became the subject of keen controversy, it has only been allowed in exceptional cases such as treatment by herbalists and homoeopaths.

Drugs are dispensed by registered pharmacists or by a person who for three years immediately prior to the passing of the Act had acted as a dispenser to a duly qualified practitioner or to a public institution. At their meeting the pharmacists expressed themselves



satisfied with the terms they had obtained under the Act. Drugs are charged to the Insurance Committees at a special tariff which has been agreed.

In his agreement with the Committee the doctor is required to furnish a person with such certificates as are necessary to enable him to establish his claim for sickness or disablement benefit. The insured person is allowed to choose a doctor; if he does not choose one then the Committee assign him to a certain doctor. Transfer from one doctor to another can be effected at any time with the consent of both doctors, otherwise transfers can only be made at the end of the medical year by giving one month's notice.

At the request of her representatives Ireland was specially excluded from medical benefit and the cost of the benefit was deducted from the contributions payable by the employer and the employed person. This turned out in practice to be a serious drawback, because of the approved societies requiring medical certificates from their members to support their claims, so a supplementary grant was made of £50,000 to enable the panel system to be formed in Ireland solely for the purpose of signing medical certificates. The doctors receive a capitation fee of 9d. and upwards per person per annum for each person on their list.

On July 15th, 1912, the National Insurance Act (1911) came into operation. The principle of the Act was its compulsory provisions which have been the most striking departure in English legislation. The Act is divided into three parts, the first part dealing with health insurance, the second part with the unemployed insurance, and the third part with matters common to both.

The first part embodies and improves upon many features of the German sickness and accident insurance. The principal features of the English National Insurance Act are:

- (1) That it applies to practically every person in the United Kingdom employed at a rate of remuneration not exceeding £160 per annum in value.
- (2) Its compulsory character.
- (3) The absence of expensive collecting machinery.
- (4) The flat rate of contributions and of benefits (with certain exceptions which an amending

Bill now before the House of Commons proposes to abolish) for all persons entering into insurance within twelve months of the commencement of the Act.

- (5) The employer still continues liable for accidents as hitherto, but sickness funds of societies are relieved when compensation is paid by the employer.

Four authorities, known as Insurance Commissioners, have been appointed to administer the Act in England, Scotland, Ireland and Wales.

Broadly speaking, all persons, whether British subjects or aliens, male or female, married or single, between the ages of 16 and 65, engaged in manual labor under a contract of service, whatever their earnings may be, and all such persons engaged in work other than manual labor whose earnings do not exceed £160, must insure. The actuaries' report estimated the number of employed contributors for the years 1912 to 1913 at 13,890,000. This number has been exceeded by some thousands.

A person engaged in some regular occupation, on the earnings from which he is wholly or mainly dependent, may become a voluntary contributor if he is not entitled to become an employed contributor and his total income does not exceed £160 per annum. The actuaries estimated the number of voluntary contributors for the years 1912 to 1913 at 829,000, but the people have not become accustomed to the compulsory provisions of the Act and so far the number of voluntary contributors is about 20,000.

Insured persons obtain the full benefit of the Insurance Act by joining approved societies. These are societies approved by the Insurance Commissioners whose constitutions must be subject to the control of the members, and they must not be run for a monetary profit. Members may transfer from one society to another with the consent of both societies. To enable all persons to join at a flat rate and to prevent the approved society being penalized by the acceptance of older members, the societies are credited by the Insurance Commissioners with certain sums known as reserve values, the reserve value being the estimated liability which the society would accept, according to

the age of the member. These reserve values will be liquidated by a sinking fund of 1 5-9 d. out of each sevenpenny contribution paid by a man. As the entry in the first place is only a paper credit on the part of the Commissioners, the approved society receives interest at the rate of 3 per cent. during the process of converting the paper credit into cash. This, as estimated, will take about eighteen years. Societies will then be in possession of accumulated funds if the actuaries' estimate proves to be correct and they will be able to pay increased benefits.

The ordinary rate of benefits of the Insurance Act are as follows:

#### MEN.

Sickness Benefit of 10/- a week for 26 weeks during total incapacity from work, payable after 26 weeks in insurance and 26 weekly contributions have been paid.

Disablement Benefit of 5/- a week should the illness continue longer than 26 weeks, payable after 104 contributions have been paid and the insured person has been in insurance 104 weeks.

Medical and Sanatorium Benefits are now in operation and there is no waiting period.

Maternity Benefit of 30/- payable to the husband; if the wife is also an insured person she can claim sickness benefit.

For women the rate of sickness benefit is 7/6 a week for 26 weeks and disablement benefit of 5/- per week.

Aliens receive a reduced rate of benefit varying according to their age.

The method of collecting the contributions is very simple and inexpensive. A liability is placed upon the employer of affixing a 7d. stamp to a special card which an insured man hands to him and he is entitled to deduct 4d. of that sum from the man's wages. The cards have spaces for 13 contributions and at the end of each quarter they are returned to the approved society or to the post office. Insured persons fall into two classes, either members of approved societies or deposit contributors. The latter scheme can hardly be called insurance, although it has certain good features, e.g., it provides medical benefit for a very needy class. It was designed to meet the cases otherwise "uninsur-



able,' viz., those cases which would not be accepted by approved societies on account of the burden they would be to the funds. Their contributions are paid to a special fund known as the Post Office Fund. The provisions of the Act in relation to this class have received a good deal of criticism. The employer pays 3d., the insured man 4d., and the State contributes two-ninths of the benefits and cost of administration. A deposit contributor in the Post Office can only draw benefits so long as his personal account is in funds, and in addition he receives medical and sanatorium benefits. On the other hand an insured person in an approved society is entitled to continuous benefit as soon as he has completed the statutory waiting period. As the fund is mutual he can continue to receive benefits long after the amount standing to his personal credit has been exhausted. The State does not guarantee the solvency of an approved society and in the event of a deficit members are liable to make good the loss. Contributions need not be paid while an insured person is in receipt of sickness benefit and all arrears accruing in the first twelve months are disregarded in the case of employed contributors.

The principal features affecting women are :

- (1) If they marry and cease to be employed they are suspended from the ordinary benefits of the Act, but they may become special voluntary contributors, paying a reduced contribution and receiving a reduced rate of sickness and disablement benefit and also medical benefit.
- (2) The terms of re-entry into insurance in the event of the death of their husband are very generous, as all arrears which have accrued during her husband's lifetime are disregarded and in order that there should not be any danger of a married woman not understanding her rights the Act imposes the duty upon the secretary of an approved society to give her certain information on receipt of notice of her marriage or of widowhood.

It has been stated several times that the financial provisions of the Act relating to women are not satisfactory, but apparently if they fall short the Insurance Commissioners will make good the deficit out of the sums

retained for discharging their liabilities in respect of the reserve values created by the Act. The effect of this would be that the date on which benefits could be extended, if the financial provisions of the Act result favorably, would be postponed.

I do not propose to touch the unemployment part of the Insurance Act, as that only applies to certain sections of manual laborers and is quite separate and distinct from the section of the Insurance Act relating to Health Insurance. Naval and Military Forces and the Mercantile Marine are specially dealt with under the Insurance Act.

#### SANATORIUM BENEFIT.

In Germany sanatorium treatment is administered by the Pension Offices to relieve the funds of cases of permanent invalidity, but German organization does not deal with the subject in as comprehensive a manner as is contemplated by the English Insurance Act. In England the sanatorium benefit is administered by Insurance Committees. To a degree the medical benefit and the sanatorium benefit are closely related to the doctor because of the capitation allowance he receives—6d. per head per annum in respect of each person on his list is for the domiciliary treatment of tuberculous cases. The importance of this point will at once be seen now that patients do not hesitate to consult a doctor who would be in a position at an early stage to recommend him to apply for sanatorium benefit if necessary, and so the Insurance Committee would have knowledge of the disease before it had gained a serious hold.

The section of the Act defining sanatorium benefit describes it as "treatment in sanatoria or other institutions or otherwise when suffering from tuberculosis and such other diseases as the Local Government Board, with the approval of the Treasury, may appoint." The words "or otherwise" were added in Parliament during the passage of the Bill, and are extremely important because they cover domiciliary treatment, treatment in dispensaries, and other ancillary treatment. Extensive measures have already been taken by the various local authorities in England, prior to the introduction of the Insurance Act, to combat the spread of tuberculosis, and the provisions of the Act, recognize the work that

has already been done, and are of a supplementary nature. The Act places the duty upon the Insurance Committee of making arrangements with Local Authorities or various persons who have the management of sanatoria or other institutions approved by the Local Government Board. The terms of the Act left the responsibility to the Local Authority to provide the necessary buildings. A uniform scheme to deal with the whole question in a national manner cannot leave to each authority the initiative of its own local schemes. The provision of the necessary buildings was given a national character by a government grant of £1,500,000, which was to be apportioned to England, Wales, Scotland and Ireland, according to their respective populations. The distribution of the money was to be made by the Local Government Board with the approval and consent of the Treasury. In certain counties the population is not sufficient to justify the erection of a sanatorium, and power is given for two or three counties to combine together and erect a joint building.

The Insurance Committee may also extend sanatorium treatment to dependants; this has been done in many cases. If in any year the amount available for defraying the expenses of sanatorium benefit is insufficient to meet the estimated expenditure for insured persons and their dependants the Insurance Committee may transmit to the Treasury and to the local County Council a statement of the probable deficit. The Treasury and the Council, if they sanction the expenditure, will then be liable for half of the deficit.

The English Insurance Act is very generous to arrears, and it is difficult for a person to lose his right to sanatorium benefit. Insurance Committees have grappled effectively with the subject of sanatorium benefit since it came into operation on July the 15th, 1912. The principal difficulties they have had to face were an uncertainty as to the application of these funds and the lack of experience. The subject being entirely new the Committees had no reliable data as to the number of beds they would require, and what contracts it would be advisable for them to enter into, while facing them was the fact that the amount of their income was very clearly defined. The County Councils



had not decided (some are still considering the matter) what steps they should take in the matter, and the sooner they decide the better. The administration of this benefit is improving every month, and Committees are now gaining some idea of the claims which will be made upon them, and are able to make arrangements accordingly.

The Chancellor of the Exchequer who was responsible for this Act, said, on the 25th of May, that they had already 6,000 workmen in excellent institutions and receiving the best treatment. The method of procedure of the Insurance Committee is that, as soon as notification is received of a tuberculous case, the Medical Officer of the Committee, who is usually connected with the Local Health Authority, should see the person and arrange that he is put on proper treatment; also, if necessary, that his home is made in a sanitary condition, and that the other members of the family receive advice to prevent the spread of the disease. If the case can be properly met by domiciliary treatment, this is given, and the patient kept under proper observation. When treatment in a sanatorium is necessary the Medical Officer is able to report to the Insurance Committee and make the necessary recommendations.

#### INSTITUTIONAL BENEFIT.

In Germany Institutional Benefit plays a more organized part in the treatment of disease and illness than in England. The hospital system in Germany is very different from the system here. The public authorities there *own and administer hospitals for general purposes* and not simply for infectious diseases. Patients of all classes are received in their hospitals and payments are made for all. Each authority makes its own arrangements for hospital management and also its charges. For instance:

Hamburg has four main classes and the charges for patients are respectively, 12/-, 7/-, 4/-, and 2/6 per patient per day.

Cologne has three main classes with charges of 8/-, 5/-, and 3/- per day, and members of sickness societies are admitted for a charge of 2s.

Kiel has two main classes at 4/6 and 3/- per day.

Provision is made for the patient according to the class he is in. For instance, a patient in No. 1 class would have a separate room.

In place of medical and money benefit the society may give a member treatment in an hospital, and if the member has no dependants the society must also pay money benefit of not less than one half of the ordinary money benefit which would be payable to him were he not in hospital. If there are no dependants the society is not bound to pay the money benefit, but may pay one fourth of the ordinary benefit. Hospitals are used for *checking malingering*; as the patient is under observation it can be quickly discovered whether he is ill or not. Societies can make an agreement with one or more particular hospitals for the treatment of patients. Every other public or philanthropic hospital maintained by a public association or corporation, however, must be allowed to take patients on the same terms, with certain exceptions. Most of patients treated in hospitals are in the lowest class. For instance, at the Hamburg Eppendorf Hospital in 1910, of the total of 700,000 days' maintenance, less than 6 per cent. were in other than the lowest class. Thirty-eight per cent. of all the patients were paid for by sickness societies. The prices charged to the societies by the hospitals work out at below cost; the average cost of treatment and maintenance per person per day, excluding capital costs, works out as follows:

Cologne (Lindenburg Hospital) .....	3s. 9d.
Hamburg (Eppendorf Hospital) .....	4s. 2d.
Kiel .....	4s. 1d.

If these figures are compared with those just given it will be seen that sickness societies have opportunities to obtain treatment for their members at a rate under cost, thus receiving a considerable contribution towards the relief of their fund from the local authorities. It is estimated that in 1882 there was one hospital for about 22,000 persons in Germany; in 1906 one to about every 16,000 persons. There has also been a large increase in the provision of convalescent homes. The demand for hospitals still continues and there is no doubt that it has been due largely to the sickness insurance. There are also in addition private hospitals owned by philanthropic and Roman Catholic bodies and also in the large towns there are numerous private doctors' clinics.

The following figures are interesting:

LEIPZIG DISTRICT SICKNESS SOCIETY.

Number of days for which the following benefits were given in 1910 to members.

(Number of members, 182,898.)

	Days.
Money benefit (without institutional treatment) . . . . .	1,464,728
	Days.
Institutional benefit with money benefit . . . . .	308,634
Institutional benefit alone . . . . .	87,184
	<hr/>
	395,818
Total . . . . .	<hr/>
	1,860,546
Hospital benefit was given to—	
5,451 male members for 175,525 days.	
2,865 female members for 78,428 days.	
	<hr/>
Total 8,316 members for . . . . .	253,953 days.

MUNICH DISTRICT SICKNESS SOCIETY.

Expenditure in 1910 on Institutional Benefit.

Amounts paid for treatment in—

Four municipal hospitals . . . . .	£30,831
The Hospital of the Women's Association of the Red Cross . . . . .	3,009
The hospital of the Order of the Knights of St. George, Nymphenburg . . . . .	846
Hospitals outside the district . . . . .	1,239
The Royal University Women's Clinic . . . . .	212
The Royal Surgical Polyclinic . . . . .	22
The Royal Gynæcological Polyclinic . . . . .	11
The Royal University Eye Clinic . . . . .	431
Three Eye Clinics of private doctors . . . . .	751
Five nursing establishments of private doctors . . . . .	808
Various establishments . . . . .	29
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	£38,189
A homœopathic establishment . . . . .	94
Asylums . . . . .	£1,138
Royal Psychiatric Clinic . . . . .	741
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	1,879
Bath establishments . . . . .	2,809
Sanatoria and convalescent homes and resorts—	
Society's Sanatoria . . . . .	£4,332
Other establishments . . . . .	2,960
	<hr/>
	7,292
Inebriate Homes . . . . .	13
	<hr/>
Total . . . . .	£50,276
The expenditure averaged 8s. per member. . . . .	



## KIEL DISTRICT SICKNESS SOCIETY.

Expenditure on Institutional Benefit in 1910.

- (a) Hospitals and other institutions at which cases were treated.
- (b) Number of cases treated.
- (c) Number of days of maintenance.
- (d) Average payment for maintenance and treatment per person per day.

	(a)	(b)	(c)	(d)
				S. D.
University Hospital .....	746	14,796	2	9
Anschar Hospital .....	78	2,272	2	8
Clinic for mental and nervous diseases. . . . .	99	2,081	2	9
Ear clinic .....	13	418	2	7
Municipal Hospital .....	115	327	3	3
Various private hospitals .....	85	2,700	2	9
Various hospitals outside Kiel .....	53	1,292	2	10
Through the Poor Law authorities ...	39	1,612	2	2
Total .....	1,228	25,498	2	7

The municipal hospital was used only for some special cases because the charges had been increased. One result was that some cases which needed hospital treatment did not receive it. In 1909 the number of days of maintenance in hospitals, &c., was nearly 32,000; in 1910, under 26,000.

The treatment in convalescent homes is extensively used by the societies. Some societies have their own convalescent homes or affiliate into a group. Other societies are helped by existing or specially formed philanthropic societies, and a good deal has been done of recent years in providing various forest camps in different places in the country or in forests within easy reach of the town where persons can have the benefit of the open air at night and follow their profession by day.

## HOSPITAL TREATMENT.

The outstanding feature of the English hospital system is its voluntary character. The hospitals throw open their doors to the necessitous and give them the best treatment without charge.

The National Insurance Act in England apparently was drafted on the understanding that these conditions would continue, and this has proved to be the case so far. There are no compulsory provisions in the Insurance Act which makes it incumbent upon approved societies or insured persons to contribute to the hospital.

In two cases only does the Insurance Act take cognizance of hospitals. In the first case it provides that if an insured person who has no dependants is an inmate of an hospital, it is open to the approved society to enter into an agreement with the hospital and pay the whole or any part of the insured persons' benefit to the hospital. The same provision holds good for asylums, convalescent homes, or infirmaries supported by any public authority or out of any public funds, or by charity or voluntary subscriptions. Some hospitals have been able to obtain contributions from the approved societies, but the difficulties are of a "competitive" character, as the sub-section which gives power to the approved societies to enter into an agreement with the hospital has a proviso that if an agreement is not entered into, the benefit may be applied otherwise for the insured person's benefit. It will be seen, therefore, that the society which enters into an agreement with the hospital is placed at a disadvantage in its endeavors to secure members as compared with a society which applies the sickness benefit otherwise for the insured persons' benefit, and the hospital suffers.

Another clause in the Act makes it lawful for an approved society to grant such subscriptions or donations as it may think fit to hospitals, dispensaries, or other charitable institutions. It is too early to say whether advantage will be taken of this section, but as the effect of the hospital treatment would be that the insured person would recover more quickly than if he did not have the opportunity of being attended in this manner, the funds of the approved society would receive relief corresponding to the general average reduction of the number of weeks or days effected in each illness so treated. It is not an unreasonable demand that some, at any rate, of the benefit which so accrues to the approved society should be handed to the hospital, but in order that a hospital may take advantage of this Clause an agreement for the purpose must be come to between the society or committee and the hospital, so that the society may give a donation or subscription to hospitals. Very few hospitals have made application up till now, as conditions will no doubt be laid down by the Local Government Board which will to a very large extent interfere with the present

management of these voluntary institutions; for example, they will demand that the hospital will be open to inspection at any time by any of the Board's officers or inspectors; that such records will be kept in connection with the hospital as the Board, after consultation with the Insurance Commissioners, may from time to time require; and, further, they may demand that the Board be informed of any proposed alteration in, or addition to, the medical staff of the institution. This strikes at the root of the whole voluntary principle and is likely to interfere so materially with the progress and efficiency of these institutions that the managers will hesitate to hand over their institutions to be so governed. In July, 1911, the Chancellor of the Exchequer was good enough to receive a deputation from the British Hospitals Association, and at that interview he stated that he was glad to meet those competent to speak on behalf of the hospitals of the country, and he thought that the representatives of the voluntary hospitals were laboring under a misapprehension when they put forward their views that they would be adversely affected by the passing of the National Insurance Act, so far as finances were concerned. He said he considered that "the hospitals of the country were essentially a part of the machinery of civilization, and he could not imagine any country allowing a single hospital to be closed." But even with the amendments made to the Bill, up till now no provision has been made for institutional treatment, beyond providing sanatoriums for the treatment of tuberculous cases. When an insured person requires a serious surgical operation performed, or requires treatment by a specialist and skilled nursing, he must seek admission to a voluntary hospital. On the 29th of July, 1913, the question was raised in the House of Commons with regard to Section 12 of the principal Act, which provides that the sickness or maternity benefit should not be paid to a person who was an inmate of a hospital, or any institution maintained by voluntary subscriptions. The Financial Secretary to the Treasury is reported to have said: "The actuarial calculations assumed that every sick man or woman would receive full sick pay in some way or another, and the time had come when it should be declared that every man or



woman would receive sick pay. A sick man or woman ought to have either in kind or in cash the full amount of the benefit, and he had in mind an amendment which would ensure the payment of the benefit to the insured person. The argument might be put forward that some of the money should go to the hospital. If the insured person were willing some of the benefit could go to the hospital, but he would be very chary in making over to the hospital the whole of the benefit." He further added: "There ought not to be any pressure put on the patient to sign away his sick pay to a hospital, and he moved an amendment which would ensure that the benefit should be paid to the patient upon leaving an institution in a lump sum, or in instalments, or applied as the particular society or committee thought fit.' The question arises, Will the voluntary principle stand this strain? For my part, I see no reason in the meantime to suppose that the voluntary hospitals in large cities will not be maintained in the future as they have been in the past, but only time and experience will confirm this belief.

I would like to state that the valuable information and facts as to medical benefit in Germany are taken entirely from the work of Mr. I. G. Gibbon, entitled, "Medical Benefit in Germany and Denmark."

PRESIDENT: I should like to ask the opinion of the audience—it will take us about three-quarters of an hour to read the paper—as to whether we shall have it read through.

DR. HURD: I move that the reading of the remainder of the paper be omitted and that it be printed in our transactions.

Motion seconded and carried.

## REPORT OF COMMITTEE TO OUTLINE STANDARD COURSE IN HOSPITAL ADMINISTRATION.

W. L. BABCOCK, Chairman.

JOSEPH B. HOWLAND,

J. N. E. BROWN.

Your Committee has prepared its report in two divisions in order to cover the subject of the training of hospital administrators or executives whose future field of work presupposes the domain of the large general hospitals, and secondly, the training of graduate nurses for positions as executives of smaller hospitals and as heads of departments in general hospitals. As this division is made, it becomes at once obvious that the training of the two classes is quite distinct in subject matter, methods and practical application.

### *The Training of Physicians as Hospital Administrators.*

After careful consideration your Committee does not believe that it is practical to establish regular courses for the training of physicians as hospital administrators. A physician desiring to secure training for the position of administrator or superintendent of a large hospital should first take a position as junior assistant and learn the work from the bottom up. While it is true that only a comparatively small number of hospitals have assistant administrators or assistant superintendents, attention may be directed to the many excellent opportunities of training offered in state hospitals for the insane in the junior staff positions. The insane hospitals of New York and Massachusetts alone require over three hundred physicians to make up their medical staffs. Numerous vacancies occur annually, and in New York State the Civil Service examinations for the purpose of filling these positions are open to residents of any state. For many reasons the training in state hospitals for the insane provides an excellent foundation for work as general hospital superintendents or administrators; in fact, the regular routine, excellent methods and administrative economies practiced in state hospital work furnish the young physician with an unusual outline for administrative work in general hospitals.

Several of the larger general hospitals of the East and Middle West have from one to four positions as assistant superintendent or resident physician. These hospitals, together with the state hospitals mentioned, offer the only practical opportunities known to your Committee for the adequate training of hospital administrators or executives.

Liberal salaries should be paid assistants in training so that desirable men may be encouraged to take up the work. The time spent in training first assistants before taking charge of large hospitals should be not less than three years, and preferably longer. The assistant while attending to the routine duties of this position should be familiarized with the duties of his senior, and in this manner, where several assistants are employed, each will understudy his immediate senior. It is an economical and social error to place an untrained physician at the head of a large general hospital. A certain number of physicians so placed may learn the business, but at an economic sacrifice. The financial and professional interests of such an institution will certainly suffer materially until such time as the executive acquires a comprehensive knowledge of the many-sided requirements of the position.

*Outline of Preparatory Course for Executives of  
Hospitals and Heads of Departments.*

This course presupposes that the candidate is a graduate or registered nurse and has definitely decided to take up institutional work as a profession. The outline covers a requisite course of training for superintendents of smaller hospitals (100 beds or less), assistant hospital superintendents, superintendents of nurse training schools, night nurse superintendents, operating-room supervisors, ward and corridor supervisors and dispensary or out-patient supervisors. A modification of this outline could be used in the practical instruction of women for the position of housekeeper or matron.

The experience of two or three general hospitals that have for several years given a course in Hospital Economics, Administration and Institutional Nursing similar to the proposed standard course has demonstrated that any well organized hospital of 150 beds or



over can give such a course with great advantage to the pupils and material advantage to the hospital.

The heads of departments in any hospital providing this course are greatly benefited by their contact with graduate nurses from other schools. Their interest in their department is stimulated by the practical teaching methods outlined; for example, the matron, the dietitian or the supervisor in whose department the pupil is working is keenly aroused to the necessity of making every effort to place the practical work of her department on a higher scientific and economical level. Her efforts may be stimulated by suggestions and criticisms from members of the class.

Pupils taking this course of training should act as assistants to the various heads of departments for a limited period of time or in some capacity which carries with it a limited or circumscribed responsibility. After the course is once organized, the amount of time and attention that department heads give to pupils may be greatly minimized and experience has proven that the teaching does not become an additional burden. It has been demonstrated that the adaptability of pupils in various departments varies to some extent, but that the general average of efficiency is reasonably high, and that few pupils fail to assimilate the training in actual practice. It is not expected that all pupils who take this course will become proficient hospital executives or department heads. A small minority, as in all lines of training, have mistaken their profession and are not adapted to institution work.

The course, as outlined, is essentially a practical one and pupils should actively participate in the work of all departments of the hospital.

#### *Qualifications for Admission to the Course.*

Applicants should be registered nurses or graduates of approved hospital training schools which at least maintain the minimum standard adopted by the American Hospital Association in 1909. They should be graduates of over two years' standing, between twenty-four and forty years of age, single, in good physical health and be definitely committed to a future of hospital work. If individuals could be manufactured as wanted and human nature made more pliable, it would

be desirable to include in the qualifications for admission to the course a disposition and temperament of pliability and resourcefulness. It should also be mentioned that other qualifications being equal, the woman with a commanding presence, whose stature surmounts five feet five inches and whose activity gives promise of much potential energy generally proves the most successful in hospital work. Unfortunately all of these qualifications are seldom combined in one individual.

Nurses who seriously contemplate making hospital work their vocation should first carefully take an inventory of their mental assets in temperament, tactfulness, adaptability and their physical assets in stature, physique and endurance. A conscientious survey of these personal qualifications will unquestionably avoid future disappointments.

### *Length of Course.*

The course outlined covers a period of six months' practical work, including several didactic lectures. With this outline as a basis, courses of shorter duration in special hospitals could be arranged, notably in psychopathic, obstetric, contagious, tubercular and pædiatric work. Special courses in the administration of surgical departments and practical hospital house-keeping could also be arranged to cover a period of two or three months. A practical course in "hospital dietetics and food service" could be given in a like period.

### OUTLINE.

#### *General Management.*

Responsibilities of Superintendent; by-laws, rules and regulations; organization of departments; selection of department heads or supervisors; relation of hospital and its officers to the public; relation to city and county poor departments, associated and private charity organizations; co-operation with other institutions; attitude of local newspapers; relation of executive to Board of Trustees, attending Medical Staff and auxiliary hospital workers; management of resident Staff; appeals to public for financial assistance; nature of general and special bequests and endowments; investment of endowment funds; legal relations of hospital,

its officers and employees; preparation of annual reports; preparation of specifications and contracts; general care of grounds and buildings; plans and location of new buildings, ambulance service; fire, elevator, liability and industrial compensation insurance.

#### *General Business Department.*

Classification and training of office clerks; business principles and methods, including hospital bookkeeping; filing of records and reports; hospital statistics; office blanks and records; sources of hospital income; preparation of pay-rolls; cash balances; cost accounting, telephone service; reception of visitors; relation to other departments of hospital; receiving and recording patients' property; credit accounts; collection of old accounts.

#### *Training School Department.*

Methods of teaching; clinical or bedside demonstrations; demonstration room; preliminary course of training and special teaching of probationers; engagement of candidates; ethics of nursing; relation of training school officers and supervisors to pupils, to patients and to other departments; training school blanks and records; preparation of curriculum; assignment of head nurses and rotation of pupils; organization of night service; keeping of time books and ward and corridor inventories; construction, care and management of nurses' home; economy in the use of supplies; alumnae work.

#### *Matron's or Housekeeping Department.*

Management of central and branch linen rooms; sorting, storing and reporting of flat work; checking and issuing linen room supplies; management, duties and obligations of housekeeping employees; stock requisitions for dry goods, crockery and housekeeping supplies; housekeeping time books; pay-rolls, blanks and records; classification, discipline and housing of employees; waste of food in pantries or dining-rooms and economy in the use of supplies; sale of old rags and other waste; destruction of vermin; inspection of waste and garbage.



*Laundry Department.*

Study and arrangement of laundry machinery; limitation of hand work; marking, sorting, washing, mangling, starching and ironing; soap making; checking and issuing of washed goods; systematic and economical handling of soiled and washed clothing; handling of clothing of nurses and employees.

*Steward's Department.*

Contracts and bids for supplies; purchase of general supplies, provisions, perishable goods, furniture and special equipment; store-keeper's records; requisitions for, and issuing of, supplies; monthly inventories of material stock and daily and monthly issue sheets; marketing for fruits and vegetables; per capita allowance of provisions; waste of supplies; economical handling of meats and dairy products; meat cutting; co-operation between steward's department and kitchens.

*Kitchen Department.*

Kitchen management and division of work; preparation of food; delivery of prepared food from kitchen to pantries and diet kitchen; menus and dietaries; food waste; requisition for supplies; diet kitchen management; pantries and handling of pantry supplies; arrangement of kitchen and pantry equipment; trays and tray service; keeping food warm; night food service.

*Surgical Department.*

General management; receipt and issue of supplies; blanks and records; sterilization methods; preparation and care of dressings and sutures; supervision and assistance in operations; preparations for anaesthesia; administration and choice of anesthetics; selection and care of instruments; planning, heating, lighting, ventilation and equipment of operating rooms; ward and corridor surgical dressing rooms; operating room economy.

*Pharmacists' Department.*

Preparation of contracts and requests for bids; purchase and issue of supplies; monthly inventory and

other reports; checking of prescription and issue records; storage of supplies; care of rubber goods and special surgical equipment; care of poisons and antidotes; pay requisitions for extras and special preparations; purchase of alcohol in bond.

#### *Wards and Corridors.*

Special supervision; practical teaching of supervisors in the training of nurses; general care of patients; care of equipment; requisitions and recording of supplies; relations to resident and attending medical Staffs; relations to superintendent, superintendent of nurses and other officers; attitude towards visitors.

#### *Out-Patient Department.*

Planning, equipment and organization; special relations to in-patient department; clinical records and statistics; dental and other special clinics; school and visiting nurse work; relation to social service department.

#### *Resident Staff.*

Duties of resident physician, of house surgeon, of house physician internes; admitting of patients; treatment of accident and emergency cases; arranging of appointments; classification of patients; handling of attending Staff patients; calling of coroner, police, priests and county attorneys; consent of relatives for autopsy; handling of chronic and convalescent cases; isolation of infectious cases and care of dying; care of instruments, splints and apparatus.

#### *Mechanical Department.*

Duties of engineer, electrician, master mechanic and assistants, daily inspection of machinery, motors, etc.; heating; lighting; ventilation; refrigeration; purchase of coal and other supplies; water system; sewerage system.

### DISCUSSION.

PRESIDENT: You have heard the report of the Committee. If there is no objection it will be accepted and placed on file. The afternoon session tomorrow will be omitted. That leaves us the Social Service Section at 8 p.m. today and the morning session Friday at 10.30 in this hall. If there is nothing further this afternoon we will stand adjourned.

**THURSDAY, AUGUST 28—EVENING SESSION.**

**THE PLACE OF A SOCIAL SERVICE DEPARTMENT IN A MEDICAL INSTITUTION.**

**BY DR. A. R. WARNER,**

**Asst. Superintendent, Lakeside Hospital, Cleveland.**

The work which we now call "social service work" in a medical institution is old, in reality as old as our medical charities: it is the way of working and the larger field that is new. Last year at Detroit, Dr. Goldwater told us about the records of organized social work for the patients in the Paris Hospitals dating back to the sixteenth century and of other work almost as old. American hospitals located in larger cities without at least a committee of women to visit the sick and care for the wants that were not medical have been few, indeed, since this country has had cities; but the rapid growth in the population with the increasing tendency toward congestion into larger cities, the changed economic conditions and the problems arising from greater immigration made the old way to help inadequate, inefficient. The voluntary services of a few ladies, however sincere and energetic, could not meet the needs found or properly survey the wants of the polyglot army seeking medical charity. A new way to work became a necessity.

This new and better way, first organized in this city, is the subject of the evening. It came from the vision and the appeal of one physician, now honored throughout this land as the instigator and the founder of a nation wide movement which has made society kinder to the unfortunates and the world better. This new social service department as it was called, this stronger, more efficient visiting and relief committee was affiliated with the Massachusetts General Hospital. However, the arguments and the pleas of Dr. Cabot have carried conviction generally that the responsibility to look for the need of more than medicine and to act upon all the findings rests directly upon any institution undertaking the care of a patient. The more recent social service



departments have, therefore, been established by the institutions and supported directly or indirectly from their resources.

The place of a social service department in a medical institution is where it can best meet this direct responsibility and where it can best perform its investigating and relief functions. In a hospital or dispensary, as generally organized to-day under a superintendent representing a board of trustees and acting as the established common point for the correlation of the varied activities and functions, the best place for the social service department seems to be squarely by the side of the other departments in the hospital organization. Here only can direct responsibility for this work be properly assumed; here only can the work be done in absolute harmony with all the rest of the institution; and here only can fitting recognition be given a work that has become a profession. It is as truly hospital work as any and is sufficiently different from any other work to make a separate department advisable. At the head of this social service department there should be an expert and professional social worker, the best the institution can get. The titles and terms of service are immaterial, but it must be a person capable of directing the social work as the nursing head or the chief engineer or the chief of a staff directs their respective departments. The organization of the department under this directing head is beyond the scope of this paper, but if there be the proper relationship between a competent department head and the superintendent, the department will soon have the personelle and the equipment to keep its work on a level with the general work of the institution.

The relation of the social service department to the other departments should be that of mutual helpfulness. The value of social work to medical work as well as the value of medical work to social work is now beyond question. The hospital has definitely committed itself to assist its accepted wards in many ways instead of one; it matters not the station of the worker, all is for these wards and their welfare is the common end of all.

In the relation of the social service department to the superintendent and to the hospital there should be the usual institutional harmony and a recognition of the

superintendent as the representative of the trustees and of the institution, itself a charity, which, in turn, represents a specialization in society's efforts to better itself. The basic aim and purpose of all departments of the hospital is to further this same effort, each in its own way. Absolute loyalty to the interests of the hospital is as essential in this department as in any in the institution.

All of the work of the hospital primarily social properly comes to this department. In addition to the recognized field for the betterment of the patients and their families there are the social investigations to determine how much, if any, a doubtful applicant can and should pay for the services to be given him. If the customs and conscience of all communities in dealing with hospitals are the same as in Cleveland, the cash return to the hospital from the abuse prevented will pay to any institution doubly the cost of this home investigating. There is, besides, no small degree of philanthropy and social betterment accomplished by preventing a man from first securing unwise charity, even though this be accompanied with some unpleasantness. There is, also, the social work for the hospital employees to be done. Commercial plants employing no more people find it profitable to provide a social worker to help their employees when unfortunate. Therefore, what reason can there be in not doing this work when the institution already has the department and workers at hand? In general the social service department should assume *all* the social problems of the hospital, as the engineers assume the mechanical or the staff the medical, and should cheerfully permit its results to be blended with the work of the others to increase the institution's usefulness to society.

The relation of the superintendent to the social service department is a proper point to discuss here. In the textbook, "The Modern Hospital," by Hornsby and Schmidt, the first paragraph of the chapter on the superintendent is as follows: "The Superintendent of the hospital is the executive officer of the board of directors, the general manager of the corporation. Standards of hospital administration have been practically revolutionized within the past five or ten years and the standards of hospital managers have changed within the

same time. The man or woman who was a competent hospital director a few years ago may be to-day so far behind the times that the whole institution is out of date." On the general manager, as Dr. Hornsby calls him, depends much of the effectiveness of the work, as well as the working efficiency of *any* corporation. The position is indeed a trust. Hospitals are medical institutions organized to do for the masses what the physician does for his individual patient, and the vision of the progressive hospital has followed the leaders of the profession from therapy to prophylaxis. But medical prophylaxis for the mass and for the community is sociology, applied, active, practical. In other words the most marked recent changes in the purpose and the work of hospitals are, first the development of more co-operation with other organizations of the community, to develop greater sociologic efficiency, and second, a greater effort to render real service to its wards as men and women, who lived some way before they were admitted and who must live somehow after their discharge, and to do this without losing one iota of scientific progressiveness or teaching proficiency. The successful manager of such a corporation must have an interest in and knowledge of public health and welfare, of social and economic conditions, and must cherish a determination that society shall gain, not lose, because a charitable institution is entrusted to his management. The results of good business are dollars of scientific research facts, and of wise charity social betterments. There should be the element of charity in every hospital and the manager must produce the results. The superintendent should, therefore, be a leader, a supporter and a fellow-worker in social service. We have heard hospital superintendents characterized as good housekeepers, good innkeepers, good accountants, good specialists in some branch of medicine. It is high time we heard, occasionally at least, of hospital superintendents that were good social workers, good sociologists. To the business, mechanical and medical qualifications required in the hospital manager to-day, to-morrow will add one more and that will be sociologic. And then the relation of the hospital superintendent to the social department will be the same as to the business, to the mechanical, or to the medical departments.



The cost of social service, as of any charity, is complicated; for the results are not all measurable in dollars, and it is not possible to reduce social results to a common basis even for comparison. It is also wrong to look only at the gross cost; for one dollar counts as another in the expense column, though the one be wasted and the other enable a man to meet misfortune and survive with self-respect and the spirit of manhood unbroken. Again, a dollar saved is a dollar earned. If the social service department saves the hospital a dollar, why should it not be credited to the department, figuratively at least, to reduce the effect of the "extra expense of social service", as it is sometimes called? The social work for the hospital employees and the social investigation of applicants for admission *always* brings a profit to the hospital, the one in greater working efficiency and the other in cash. There is another kind of saving, however, that counts for more than these. The best story at hand to illustrate this is, by chance, local. It is best because the data was worked out best and not because there is anything unusual or uncommon in the facts. As a story to illustrate the weakness of dispensary treatment it would be commonplace indeed. Some of you at least have heard Miss Cannon's story about the family with scabies. This family consisted of the parents and nine children. The long records of every member, all for the same trouble, were noted and investigated. Miss Cannon found that they had come to the dispensary three years before. The total number of dispensary visits were 110, which figured at the per capita cost amounted to \$52.65; free prescriptions were given them costing \$23.70. They were treated in the hospital wards 71 days, costing \$178.92, and making a total of \$255.27.

Over three years of treatment costing this amount of money had failed. After a few visits of the social worker to this home, costing but a few dollars, the family had learned enough hygiene to bring a prompt and permanent cure under the same medication. Were these few dollars an extra expense or did it save the cost of more unsuccessful dispensary treatment and become an investment that returned a profit of some hundreds per cent. in cash besides the service rendered the family? I have seen social service work for dispensary

patients unquestionably prevent a second break in heart compensation. If the break had come this patient would have been returned promptly to the ward. Is the social service in such cases an extra expense or is it a way to save the cost of some weeks of hospital care at the usual figure? Above the dollars there is a higher plane; it is better charity to keep a man out of a hospital bed than to care for him after he is in one. There is something wrong with the social service department that can not add to the efficiency of any institution sufficiently to enable it to accomplish the same amount of good in the community at an equal or a decreased cost. Added to a given institution the department will widen its influence and strengthen its work far beyond the ratio of the extra expense.

The gross cost of a social service department is about \$1,200 a year for each worker, including incidental expenses, a room or desk room, and a little fund for loan and emergency relief, which can be raised easier than money for any other use in the hospital. Then why should any hospital be without such a department?

I am assured that the New York City Committee on Hospital Inquiry, a lay committee, seeking only to promote economy and efficiency in the care of the municipal poor, will report that social service in the cities' hospitals and dispensaries is a "necessity because it increases the effectiveness of the medical relief," because "it safeguards the community and promotes social efficiency" and "that it is therefore a legitimate part of the municipal expenditure." Not long since the presence of X-Ray equipment marked hospitals as good, then the absence of such branded them as bad. The history of hospital social service will soon have been the same.

## DISCUSSION.

PRESIDENT: Dr. Warner is obliged to leave town to catch a train. We will discuss his paper first and not with the others. Dr. Warner's paper is open for discussion. If there is no discussion on Dr. Warner's interesting paper we will go on to the next.

MR. BORDEN: Renewing my proposition of this afternoon, I think there ought to be a discussion of this paper. It is a happy coincidence, if not more, that the first section of social service work of this Association occurs in Boston, where Dr. Richard Cabot, with the co-operation of the Massachusetts General Hospital, started in the scheme of connecting up the hospital with the community, something that was coming in the evolutionary process as a necessary result, but something which I do not think that Dr. Cabot or the Massachusetts General Hospital appreciated when they started in on social service work; in other words they builded better than they knew. We have had papers all through this Conference which show the tremendous factor which the hospital is for the benefit of the community. The hospital before the institution of social service work was a machine devoted to those that came within its doors. Today, connected to the community through the social service department, it is a community factor making for the good of our civilization in the United States, where we have become sufficiently enlightened to recognize the importance of social service work, and I think that papers like this ought to be emphasized, not only by approval, but by criticism, by discussing of the topic by people who are competent to understand the situation, such as your superintendents of hospitals are, and I hope there will be a broad and free general discussion of social service work at this meeting tonight.

PRESIDENT: I am not at all sensitive about this case of scabies, for I have heard of that in social service papers before. I have heard those cases quoted in at least half a dozen papers in the last three or four years. I hope those social service writers will get a new incident to write about. That is not because I am superintendent of the hospital where it occurred. Is there any further discussion?



## SOCIAL SERVICE IN AN OUT-PATIENT DEPARTMENT.

BY ELIZABETH E. V. RICHARDS,

Head Worker, Social Service Department, Boston Dispensary, Boston, Mass.

Knowing that the American Hospital Association is organized for the "promotion of economy and efficiency in Hospital Management" I shall confine my talk on Social Service to its relation to those two administrative features. Of Social Service in relation to progressive Medicine and to the humanitarian side of medical care I shall not be able to speak, although to both it has a contribution to make. I wish also to emphasize the fact that in America, Social Service, in an organized form, is but eight years old. A beginning only has been made and each year does and should see changes in its program. Also as the needs of one hospital are quite different from those of another, so should the character of a Social Service vary in each institution and again in each city according to its local charitable and health problems. Social Service is a tool whose value depends on two factors—the training and experience of those doing the work and the use made of it by administrators and physicians.

It was in the Out-Patient Department that Social Service had its beginning. That its need was first felt there may have been due to a sense of ineffectiveness of which a physician is far more conscious in an out-patient department than in the wards of a hospital. In the latter he is given every facility for painstaking and thorough care of his patients; the opportunity for their control including the entire regulation of their daily routine; every tool for expert diagnosis and treatment is available. Above all, as a patient remains in the hospital in most cases as long as the physician feels it necessary, he may look forward to a reasonable period of time in which to test his diagnosis and observe his patient's reaction to treatment. How different from the situation in an out-patient department! There patients file by in rapid succession. There is often little time for thorough examination and the

equipment of an out-patient department has, in many instances, suffered in comparison with the needs of the wards. The assistance necessary for careful recording is too often lacking and, above all, many patients do not come back. Treatment is prescribed half-heartedly with the knowledge that much of it will not be, cannot be carried out. Dr. Cabot describes this situation so vividly in his first annual report when he says, "There occurs many times each year a scene not unlike that described in Alice in Wonderland:

"Have some wine," said the Hare.

"I don't see any," said Alice.

"There isn't any," said the March Hare.

Without any sense of the humor and pathos of the situation we say (in substance to many patients): "Take a vacation, get a job, get a set of teeth, or get a truss. There is none in sight and no means of getting any."

Social Service is not a panacea for these problems, but Social Service can offer definite lines of assistance to the physician and administration, which may lessen certain discouraging aspects of an out-patient service. The most obvious one and, therefore, the one on which most emphasis has been placed, is that in connection with making treatment possible. The explanation of this may lie in the evolution of medical service and medical science. The first in the passing of the family physician and the second in the passing of pills and powders.

The passing of the family physician intimate with the whole background of his patients' lives leaves the doctor in an Out-Patient Department to suffer under disadvantages unknown to the old family practitioner. Lack of knowledge of a patient's inheritance, home condition, domestic problems and financial status are all handicaps to diagnosis and treatment and ones which the Social Worker can materially lessen by home visiting and by added interviews in the dispensary.

The passing of pills and powders and the substitution in many instances of fresh air, rest, wholesome food and recreation has left a gap not met by the apothecary. In the first year of one Social Service Department 1,000 patients were referred for more than fifty reasons. These reasons have been classified into what

might be called Social Prescriptions found necessary by the doctor as part of treatment. They include instruction in hygiene, temporary home during treatment, provision of glasses, orthopedic plates, false teeth, special diets, general health built up previous to operation, provision for unmarried mother. Bad habit to be broken, home and industrial adjustment for the cardiac, tuberculosis and many others.

In order the more effectually to give this personal service to the individual patient, Social Workers have been finding it necessary to develop their organization and methods of work in a somewhat different form than was anticipated. The first Social Workers were placed in an office which constituted in medical parlance a Social Clinic. To this clinic or department were sent those patients for whom the physician asked special help. Thus the choice of patients for Social Service was entirely dependent upon the interest, leisure and ability of the doctors to select them. In many Social Service departments it was not at all uncommon, nor is it today, to have referred from the same clinic with each change of service quite different types of problems. From a given clinic during one doctor's service only patients needing convalescence would be referred. During the next doctor's service unmarried, pregnant girls would be sent. During a third doctor's service the majority of patients referred would be those requiring an operation, and to plan for the family during the absence of the bread-winner or home-maker would be the demand. This irregularity of opportunity made Social Service seem a matter of accident and those doing the work could feel no assurance that the patients sent them were the ones which they were most likely to be able to help, for in Social Work no less than in medicine there are ills for which cure or relief is still unfound, as the chronic loafer, and others again for which there is almost as sure a specific as quinine for malaria. These unsatisfactory features of Social Service combined with others realized in the day's routine brought up the questions for which there seemed no available answer:

What are the problems of an Out-Patient Department? In which of them, and in what ways may Social Workers be of use?



Such questions are in reality for the administration of an Out-Patient Department to answer. To answer them two steps are necessary: First a chance to study the facts, and second, a chance to experiment under favorable conditions. In both steps Social Workers have been enlisted.

To illustrate: In studying a general medical clinic it was found that of the total number of patients coming for treatment 63% of them made but one visit. The same per cent. has been found true with slight variation in a genito-urinary department and mental clinic. In the mental clinic just noted the experiment was tried of placing a Social Worker in the clinic and a result of personal visits and letters in three months the average visit per patient was raised from one to five. In a children's clinic by a postal card system of communicating with patients who did not return, the number of visits per patient was raised from two to four; while in a skin clinic in which a Social Worker sees every patient, as many as 57 patients have returned for treatment in answer to 58 letters.

In a three months' study of a mental clinic the number of cases with deferred diagnosis reached 46% of the total number, while during a similar statistical period in which there was a Social Worker in the clinic this number fell to 6%. At first sight any connection between Social Service and diagnosis may seem far-fetched, but the explanation is a simple one. The Social Worker's relation to diagnosis is largely one of following up the patients and getting them back sufficiently often to make it possible for the physician to make a diagnosis.

During a three months' service in a general medical clinic in which 30 patients were advised by the physicians to have operations only five are known to have done so—in this clinic there was no Social Worker—while in a gynaecological clinic every one of the 20 patients referred to Social Service had the operative treatment advised, and came back to the doctor so that he could see the results. The part which the Social Worker played with these patients was one of added persuasion to that of the doctors; seeing relatives and friends in regard to it; arranging for the families' care during the patients' residence in the hospital; seeing

that those patients requiring convalescent care secured it and that work was adjusted to the post-operative condition either temporarily or permanently.

In a study of 21 children with vaginitis it was found that they belonged to families consisting of 63 members. Through the efforts of Social Workers 46 of these were examined, the doctors finding in these 46, eleven other cases of infection. All 32 cases remained under treatment until discharged and those of school age were excluded from school with the understanding of the school and health authorities. When one reads in the recent studies on vaginitis the recognition that much of the so-called stubbornness to treatment and many recurrent cases are probably due to reinfection from some uncontrolled source and not as previously believed to the idiosyncrasy of the disease, these figures take on a new significance. They also raise the question: Can the average clinical physician treating vaginitis, have, without some follow-up system, the knowledge and control of his patients necessary to the cure and prevention of their disease?

Just what proportion of all treatment prescribed is secured the records of an Out-Patient Department do not tell. However, in relation to equipment ordered, as for example, orthopedic apparatus or glasses, for which the Out-Patient Department retains the measurements, very definite figures are obtainable. Previous to the follow-up work of a Social Worker in an eye clinic, as high as 60% and never lower than 30% of the patients for whom glasses were ordered failed to return for them. With the help of a Social Worker this number has fallen to 4%. Thus the addition of a Social Worker to a clinic is an economy, when one considers the time of experts it takes to test eyes, the results to the eyes and to the relative efficiency of patients needing glasses who do not receive them.

To sum up: The finding of these studies and experiments seem to show three things to be true. First, that Social Service is one means of preventing certain uneconomic features of out-patient treatment. To wit, those involving the irregularity of attendance, the uncontrolled channels for the spread of infection, and the failure to carry out treatment prescribed. Second, if the social problems of an Out-Patient Department

are to be known with anything like completeness, and met with the least waste of effort, Social Workers should be placed in the clinic where they are easily accessible to both physician and patient. Third, such study is a means of knowing in just what degree the efficiency of an Out-Patient Department is increased by the addition of Social Service. Only by such cold analysis in terms of large numbers can fallacious arguments be prevented. Social Workers have much to learn from the scientific spirit of medicine. A physician does not argue a form of treatment to be good or bad from its reaction on one case, but from its proportionate results in a hundred cases. So Social Workers are striving to make for themselves a place in out-patient service not by recounting successful individual cases, but by demonstrating in relation to the whole work of an Out-Patient Department that they can and do contribute to its economy and efficiency.

#### DISCUSSION.

PRESIDENT: I think after all we had better discuss each of these papers as read. As Miss Richard's paper pertains to social service in the Out-Patient Department, that subject is now open for discussion. Miss Cannon may we hear from you?

MISS IDA M. CANNON (Massachusetts General Hospital): I should like to hear some criticism of social service from the other people, the hospitals who are not persuaded, and then maybe I might join the discussion.

PRESIDENT: I thought every one was persuaded.

MISS CANNON: No, I do not think so.

PRESIDENT: If there are any skeptics present, please speak up. Is there any discussion on this paper of Miss Richards'?

MISS CANNON: I just want to say that I think that it is time if you have any criticisms to bring to us, it is time for us to hear some things about ourselves. I want to speak for the hospital social workers a word of warning, maybe, to those who are becoming as enthusiastic as we have been. Those of us who have had a few years of pioneer service in this new field, and have, as you know, become enthusiastic about it and have thoroughly enjoyed the things that we are doing, are beginning to see that after all we are not solving all the social problems that come to a hospital, and we do not want you to think that we can. We are simply a part of the group of social workers in the community who are trying to measure the kind of troubles that people have, and the hospital is simply one point of attack on



the social problem, and I think that the real scientific spirit Miss Richards has spoken of will make us more and more cautious as time will go on, and we will join with the other social workers in the community in feeling after all that we are students, that we are yet to see what our problems are. Some one has spoken tonight of the fact that the Hospital Association during the last fifteen years of meetings of your Association, you have been specially concerned with the internal relations of your institution. You have been trying to find out the best kind of laundry and best kind of bookkeeping and that sort of thing and now you have so perfected internal technique that you are ready to consider the effectiveness of your treatment, and it is there that we come in as measuring a part of that effectiveness and we need your criticism more than anything else now. We have needed your support, we have needed your faith, and I think the hospitals have been quite remarkable, considering the fact that they are such conservative institutions, I have been very much surprised that they have had so much faith in us, but now we need constructive criticism and I hope that will be brought out, because I am sure there are some here that have some consciousness of our failure and some question as to how much we can do for you.

PRESIDENT: Any further discussion of Miss Richards' paper?

DR. BABCOCK: Mr. President, we have not yet gone far enough for me to discuss the paper intelligently. I should like to ask, however, if the work here has been carried on long enough to know whether it is advisable in organizing social service work in a hospital to have the social service department a part of the hospital, or an independent organization.

PRESIDENT: Do you ask me? Perhaps I can say a word about that. The organization of the social service work has not been an integral part of the Massachusetts General Hospital and it has not been for one reason only, that as an independent organization it can raise money easier than we could if we took it on our own shoulders. I am afraid the interest in raising this additional sum would soon cease if it was placed upon the shoulders of the hospital, but for good organization it ought to be there, it ought to be an integral part. Is there any further discussion?

## SOME DEVELOPMENTS ALONG SOCIAL LINES IN THE WARDS OF A GENERAL HOSPITAL.

BY MISS HELEN GLENN,

Head Worker Social Service Department Hospital  
University of Pennsylvania, Philadelphia, Pa.

In order to ensure recovery from illness three things are necessary—adequate medical treatment, proper physical care, and relief from worry. If any one of these is lacking, the chance of recovery may be lessened, or perhaps altogether lost.

In the Hospital Ward, the first two are supplied to the patient; that is, he receives medical treatment, and proper food and nursing, etc., in the Hospital Dispensary only the first, medical treatment, is given. This means that there may be a lack in the care of each patient that must be filled if recovery is to be assured.

The function of the Social Service is therefore to supplement the work of the other departments of the hospital by providing that part of the care that they cannot furnish.

From the social point of view there is frequently no difference between the problems of the Ward and the Dispensary patient. The man with the broken leg is received into the Ward; the one with the broken arm is dressed and sent home. Both are incapacitated for the same length of time, and the families of both may be a care on the community.

The choice of a field for beginning hospital social service seems to have been governed by no fixed rule, in many cases. In one hospital it includes only ward patients in another only dispensary patients. In one hospital the Social Service cares for ward patients and a small number of emergency dispensary cases; in another the dispensary patients receive the most attention and only emergency ward cases are referred. In the University of Pennsylvania Hospital, while social work was begun for dispensary patients alone, we have come to see that there should be no division, and that workers should be assigned to special groups of cases whether they are treated in ward or dispensary.

This theory has worked out especially well in the Children's Medical Work. Our children's worker or her assistant is in the dispensary every day with the doctor. She sees all the children that are brought for treatment and takes a brief social record of each on the back of the medical record. Often the doctor consults her before sending a child into the ward, for if the nature of the disease and the nature of the child's home warrant it, he prefers to treat him in the Dispensary.

The worker also goes to the ward each day, and arranges her time so that she may be there during visiting hours, to become acquainted with the mothers. She can thus often discover whether the mother can give the child the after-care that will prevent a relapse on its discharge. From both ward and dispensary, the worker chooses the children that need home visiting and the usual follow-up work. At first the doctors made the rule that no child should be discharged from the ward without the signature of the Social Worker on the discharge slip. This proved to be an unnecessary formality, because of the close co-operation of nurse, doctor and Social Service Worker, and has been dropped.

The sound economy of this work for children may be illustrated by the contrast of two cases. The first might be duplicated a hundred times from the records of any general hospital where there is no Social Worker in the Children's Ward. The record states that Mamie W., nine months old, was admitted in 1910 with chronic intestinal indigestion. The child was admitted and re-admitted to the ward four times, and spent there sixty-four days in all. There was every indication of lack of home care, and on the last re-admission the child died.

Since Social Work has been started this is the kind of result that can be expected: Morris Z., twenty-one months old, was admitted in October, 1912, with rachitis and indigestion, was in the ward ten days. After his discharge the Social Worker made six visits to the home and the mother came frequently to the dispensary for advice and instruction. Our record for Feb. 15th, 1913, shows that Morris is fat and well, has gained ten pounds since leaving the ward and equally im-



portant; the mother understands his care. The treatment of the first child who died, cost the hospital approximately one hundred and forty dollars and eighty cents (\$140.80), the treatment of the second child, who lived, cost the hospital twenty-five dollars (\$25), including about three dollars (\$3.00) for the services of the Social Worker. For the cost of three days' treatment in the ward a child can be kept under supervision for three weeks after it leaves the hospital. Since the plan of working in both ward and dispensary has proved successful with children's medical cases, we are trying to apply it to the other departments of the work.

For a year one of our workers has given two hours a day to teaching the children in the Orthopedic Ward. This has been worth doing for two reasons: It has immediate value both as diversion and mental stimulus to the children, and helps them to pass the long hours that are so full of listlessness and pain. It also enables the worker to find out the child's habits and inclinations and frequently to form some plan for his training after he leaves the ward.

Last year we were obliged to assign the follow-up work for crippled children to one worker, the teaching in the ward to another. This year all the social work for crippled children, including the teaching, will be done by one person. Her visits to the home after the child has been discharged will therefore seem a natural outcome of their long acquaintance in the ward.

Though the ward and dispensary patients present many common problems, those of the former are much more limited in kind. In the wards of a general hospital, the Social Worker occasionally finds epilepsy, feeble-mindedness, insanity, syphilis or tuberculosis. In the dispensary, these and a dozen other diseases of profound social significance are met with daily.

On classifying the needs presented by twenty-five patients from the Women's Medical Ward, we found that fourteen had required convalescent care, eleven were much worried about home conditions, and ten were so ignorant of hygiene and correct diet, that without instruction they almost inevitably would have relapsed. Besides these three groups which in medical and surgical wards seem always to be largest, two of

the number needed special appliances for which they could not pay; one was incurable and required permanent institutional care, one needed temporary relief after leaving the ward, and two required supplementary care at home in the way of special food, etc. Six other social agencies in the city helped us to provide the necessary care for these twenty-five women. Each of the first three groups perhaps needs a word of description. First in relation to convalescent care: With most of us the period of convalescence shades gradually from sickness to health—for the poor there is, between the two, a grim economic line. A wife's report on her husband's health may be, "He was well enough to go to work this morning," or "He was sick and missed three days of last week."

Convalescent care for ward patients, helps to make permanent the results of the treatment given in the hospital and it is surely not extreme to say that a sick person has as much right to proper convalescence as he has to treatment when acutely ill.

Frequently our physicians are able to send patients out of the ward sooner when they know they are going to a convalescent home. Last year in our Summer Convalescent Home for Women, forty-eight women were cared for. In November, three months after the home was closed, we made an inquiry to find whether the results of the cure had been lasting. We learned that of the forty-eight women, thirty-seven were well, or as well as they ever could be; four were not found; and the remaining seven had had relapses. In consideration of the severe illnesses these women had undergone, the results were better than we had hoped for.

Secondly. In relation to the group of women who were worried about home conditions: As a rule the mental distress of the ward patient is apt to be worse than that of the one who attends the dispensary. As they express it themselves, "There is nothing to do but lie and think." Frequently they will go home to be with their family in trouble even though they realize that by returning home they not only cannot help the family, but in reality add to its burden. Or sometimes the need arises after the patient has been in the ward for some time. A man who had expected to stay in the

hospital for six weeks is told that he must stay longer. His sick benefit has run out, and he knows that his family will suffer. If such a patient leaves the ward and goes to work too soon, he often comes back to the hospital in a more serious condition than at first.

Perhaps emergencies arise at home. In one hospital, an unwise neighbor brought word to a woman with a serious cardiac trouble that her children, whom she had placed with a friend, were lost. The woman sprang out of bed and ran the length of the ward to get her clothing to go out to find them. The Social Worker persuaded her to go back to bed, with the promise that she herself would start out to hunt the children. In an hour she was back to tell the woman that they were found, and that she would see that they were cared for until the mother's return. In such instances the Social Worker can prevent the interruption of the treatment and the consequent loss of the time spent in the hospital.

The third large group of patients are those who need instruction in diet and general hygiene. During the last years some of the physicians in the Medical Dispensary were impressed with the poor results they were getting in patients with the various forms of gastrointestinal disorders. They therefore asked the Social Service to receive these patients for instruction and supervision along diet lines. A group of fifty thus studied was made up chiefly of patients who had attended the dispensary for some time and in many instances had spent weeks in the ward only to relapse on their return home.

The majority of patients represented the various types of digestive disturbances, gastric neuroses of various grades and types, especially that associated with hyperchloxydria, gastropnoxis, gastrectasis, a few cases of gastric ulcer, and one of chronic appendicitis awaiting operation. There were also a few patients representing the various types of metabolic disorders, arthritis, nephritis and diabetes.

While, of course, in such cases the physician instructed along diet lines, it was impossible for this instruction to be entirely practicable without a knowledge of the family income and expenditures, the patient's habits, and the prices of foods required by the treat-



ment. The physician therefore outlined for the Social Worker, who was also a trained dietitian, what diet he wished the patient to follow, and it was her task to adapt and interpret it for the patient. This work involved the whole question of household management, the health and diet of the rest of the family and the adjustment of expenditures.

Of these fifty patients, ten were unsuccessful, or the results were unknown. This was partly due to the fact that habits of diet are difficult to change, and also that some of the number lived outside the city and could not be visited. Seven patients were referred so recently that the results are still indefinite. Five are patients with gastric ulcer, three of whom are to be operated on. In these five, despite the condition, there has been some improvement. Twenty-eight patients showed marked improvement, and most of them are now well and back on a general diet. The doctors feel that the experiment of the past year has been a success, and we are hoping to extend the work to a larger group of patients from both ward and dispensary this coming winter.

While speaking of the patients that are admitted to the wards, there should also be mentioned those who need this care, but for some reason cannot be admitted to the hospital to which they apply. In the case of children, the ward may be in quarantine; sometimes it is full; sometimes the child has been exposed to contagious diseases. Again the child may have a disease, syphilis, tuberculosis, etc., which is not treated in the wards of a general hospital. Surely, however, the hospital owes something to these patients who apply for admission. Over and over again one hears the pitiful story of a woman who has gone from hospital to hospital trying to place her child in the ward, each time being refused, but never directed to the hospital which really will receive the child. One case recently sent to the University Hospital illustrated the need? A little girl of thirteen was brought down to the city by a physician from a country town in New Jersey. She had an empyema that required immediate operation. Unfortunately she had been living in a house where there was measles, and so could not be admitted into the Children's Ward. The physicians did not know the

other hospitals of the city, and the chief resident brought him to the Social Service Department for advice. Another hospital which had a room for the isolation of such cases and was willing to receive them was suggested and the doctor was able to place her within half an hour of the first application.

The Social Service of the Pennsylvania Hospital in Philadelphia, makes a special study of these receiving ward cases, and every patient who needs hospital care, but cannot be admitted, is referred to them, with a note from the examining physician, stating the diagnosis and the reason for refusing admission. Placing such patients without loss of time involves a knowledge of the medical resources of the city, on the part of the worker, the persuasion of parents, escort to the other hospital, etc.

From Feb. 1st to July 1st, 1913, forty-six children were referred from the receiving ward for hospital care. They fell into the following groups: Thirty-one children were medical cases, under six years of age. The Pennsylvania Hospital has no ward for children's medical cases. These thirty-one children were therefore placed by the Social Service in nine other hospitals. Ten children required surgical care, when there was no room or the children's ward was under quarantine. These ten children were placed in four other hospitals. Five children had contagious or infectious diseases, syphilis, measles, etc., and were placed in the City Hospital.

During the same period, thirty-six adults were referred. Seventeen were suitable for admission but there was no room for them and they were placed in six other hospitals. Fourteen of the number had contagious or infectious diseases and were placed in two other hospitals. There was also a group of five patients, one of epilepsy, two of pregnancy, and two of alcoholism; and since these conditions are not treated in the Pennsylvania Hospital, the patients were placed in three other hospitals.

The question of the selection of cases in the wards for adults is an interesting one for the social worker. In the beginning we felt that it might be unwise for her to choose her own cases, since it might lessen the in-

terest of the physicians in discovering and referring problems to us, and might also tend to separate the social from the medical work. On the other hand if selection were left to the doctors and nurses, there was danger that in the wards where we were not so well known, much work that should be done might be missed.

In the Women's Medical Ward the question was settled by the physicians themselves. They made the request that the worker know and study all the women, feeling that she was especially able to obtain information about character and environment that would frequently have bearing on diagnosis and treatment. This, of course, takes time, some of it time that can hardly be accounted for, but a trained worker can discover fairly soon which of the patients present problems she can help to solve. In the ward of thirty will be eight or nine women to whom she can be of service. The interest of the physician has increased.

In the other wards for adults, we have thus far left the choice of cases to the physicians and head nurses, acting on our first principle that social service should be prescribed by the doctors as part of the treatment, if it is needed.

Since the ward is still relatively a new field for social work, it is difficult to tell what forms it will take in the future. Perhaps more than the dispensary, it offers opportunity for study along social lines of industrial accidents and industrial diseases. In the ward, too, one finds the person who has been handicapped by disease or accident before the demoralizing months of worry and fruitless search for work has begun. The problem of employment for the handicapped is one that the hospital worker is asked more and more frequently to solve.

In closing I would mention one more opportunity as yet undeveloped for social service in the wards. Something has been done in the maternity wards of the various hospitals for the unmarried mother and the woman with a specific infection, but the possibilities for using the ward as a baby saving station have not been generally recognized. Frequently the only time in a woman's life that she can give toward learning how to care for the baby is the few weeks of comparative leisure immediately before and after confinement. As soon as



she leaves the hospital, household duties close in on her again.

It would seem a feasible thing to have regular instruction of all mothers during part of their brief stay in the hospital. There would then not occur so frequently the rather paradoxical situation of a woman coming back to the children's dispensary a few weeks after her discharge for the instruction she might have received in the ward, before the baby became ill. To send a baby out of one ward in the hospital, only to have it brought for admission to another in a few weeks shows a lack of economy that will surely be recognized by hospitals soon.

#### DISCUSSION.

PRESIDENT: Miss Glenn's interesting paper is before you for discussion. Miss Cannon said that she invited criticism. Speaking in all kindness and with, I think, full appreciation of the great value of this social service work, I think there has been a slight tendency amongst social service workers who are enthusiastic—and properly so, for without enthusiasm they could accomplish nothing—there has been a slight tendency to take it for granted that the work which they have done has never been done at all before. In the hospital with which I am connected the assistant superintendents for many years did themselves to a great degree the work which has been spoken of this evening. For instance, a patient who was to be discharged always was inspected by the assistant superintendent before he went out, he saw to it that someone went with him if he was too feeble to go alone, saw to it that he had his ticket to his home and saw that every arrangement was made for him to get home properly. Numerous such things as that were done by the assistant superintendents. Of course when this social service movement came along and there was some one ready to do it for us and we were convinced that they could do it well, we had no objection to their doing it. There is a slight tendency to speak as though these things had never been done before. They have been done, not so well, but most of them have been done before. Then I think I discern a little tendency amongst some of the speakers to make comparisons which perhaps would not stand rigid investigation. Perhaps I did not catch just what the last speaker said, but she spoke about a child who was in the hospital and died and it cost the hospital \$100. Then a social service worker was put on and another child got well and it cost the hospital \$25. I guess I did not get the point, did I? Is there any further discussion of this paper? Dr. Peters, what are you doing at the Rhode Island Hospital?

DR. JOHN M. PETERS (Providence, Rhode Island): We are not doing nearly as much as we expect to do. Personally I am

not able to discuss these questions intelligently, but I should think some of these ladies who have had the wide experience ought to tell us men what to do.

PRESIDENT: Dr. Holt, what are you doing at the Boston City Hospital?

DR. F. H. HOLT (Boston): I will say in regard to social service, we are doing the same as you stated that you were doing at the Massachusetts General Hospital for a number of years. The assistant superintendents went to see that the patients were properly taken care of after they left the hospital and were doing just such work as the social service workers are outlining here. We have no social service workers, we have not taken it up.

PRESIDENT: Dr. Howard, what are you doing at the Peter Bent Brigham Hospital?

DR. H. B. HOWARD (Boston): It is not proper to say what we have done. I believe thoroughly in this social service work, and I thoroughly believe that we will pass to social service. At present our patients are few, our staff is large and we can sort of surround and cover that work just now. When our patients get many and our staff is more complete, we shall undoubtedly have social workers to do many of the things that the staff does now. Our out-patient department is continuous, that is, it lasts throughout the day and there being only a few patients at any one time, the women at the head of the department and the nurses that assist there are able to cover many points that you could not cover by your regular help in an out-patient department which only lasts but a few hours. Our work being spread out over the day at present, we are covering these points without a regular social service worker. That is not because we are not sympathetic with the social service work. There is one point I wish Miss Cannon might bring out, that is, the proportionate number that are helped, or that come to the social service department in the Massachusetts General Hospital Out-Patient Department, as compared with the numbers at home that come to that department. I knew something about this years ago, and I should like very much to know about what the proportion is now. Do you know, Miss Cannon, how many you have now, with reference to that department?

MISS CANNON: I do not know exactly, a very small portion.

DR. HOWARD: That is one point I wanted to bring out. I am frank to admit that they cover that work better than it was ever covered before. That refers only to a small percentage of the people that come to the department. I used to think of it somewhat in this relation that the Out-Patient Department added several new things so that they covered cases better which were covered illy before. When they added the social service department it did cover it, Dr. Washburn, better than you and I did.

PRESIDENT: Surely.

DR. HOWARD: And it saved us a lot of trouble, too, although they made us some. When they added the Zander room you took hold of a lot of cases that came from the Out-Patient Department and helped them, that we were not able to help before. They were a dead weight upon us, we did not do much for them, but the Zander room took them up and did something for them. The great bulk of the work went on as before, but with us we took a certain lot of cases and finished them up in a much more humane way and covered it more carefully and did a lot of good work.

DR. HURD: I am not personally engaged in the work at present. I attend the meetings of the trustees, however, and of the various committees. I usually find that the social service worker is always asking for an additional worker. It is astonishing how the work develops and I sometimes think that the time will come when the hospital will be a social service affair anyhow and the care of patients will be a secondary consideration. During the past year we have had one of our nurses who is a trained social service worker in charge of the department. She has had two assistants. Just before I left home I found that they had succeeded in organizing a Board of Ladies to assist her and they were raising money for another assistant. Fortunately those ladies who composed this Board of Managers were all interested in medical cases and they thought the additional assistant should be engaged wholly in medical cases. Thereupon the surgeons decided that they would raise funds and have a social worker who spent her whole time looking after the surgical cases, so that I hope by another year there will be at least sufficient rivalry among the different departments so that we may have a social service worker or two for every one of the departments of the hospital. Our new psychiatrist is hoping to develop a social service department which is in some respects to be unique. The head of this department will be in position, and it will be his business to see and personally ascertain the condition of patients who have been treated in the psychiatric department and are well enough to go home, to give them a sort of after-care, which of all things is most necessary for the patient. I believe the outlook in our institution is good for increased usefulness in the social service department. I do not believe we do as much as they do at the Massachusetts General, although possibly we do as much as Dr. Howard and Dr. Washburn.

PRESIDENT: We will now listen to the last paper of the evening.



## WHAT SOCIAL SERVICE CAN DO FOR THE CLINICAL PHYSICIAN.

BY ROGER I. LEE, M.D.,

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The general practitioner of fifty years ago was his own specialist. Likewise he did his own social service work. He knew his families and their problems and his advice was along social lines as well as along medical lines. With the increase in specialism which has been necessary to keep pace with medical progress, physicians have been compelled to recognize certain limitations in their work. A busy physician, whether in hospital or private work, often restricts his activity to one branch of medicine and occasionally even to some subdivision of that branch. He usually finds the actual medical details of his restricted field so engrossing that he pays little attention to the other branches of medicine. He has no time for the investigation and control of the patient's non-medical life. To my mind this was the situation that created the need for the Social Service Department in the Hospital.

The Social Service Department in a hospital exists, it seems to me, as a definite specialty for the diagnosis and treatment of appropriate diseases like any other special department. This specialty is very complex. At times, the use of the department is merely diagnostic, like the use of the X-Ray Department in fractures. An illustration of this would be the investigation of the home surroundings of the anaemic, debilitated child. Again, the Social Service Department is only therapeutic, like the use of the hydrotherapeutic department on the prescription of an internist. An illustration of this is seen when we refer a debilitated woman, whom we desire to sleep out of doors and to have forced feeding, to the Social Service Department. Many similar illustrations may be given. We are all familiar with the fact that in tuberculosis the clinical physician makes the diagnosis but that the Social Service Department

takes charge of the details of the further care of the tuberculous patient.

At the Massachusetts General Hospital, and I presume in all general hospitals that have Social Service Departments, certain groups of cases are referred to Social Service practically as a routine. We refer all tuberculous patients, all women with venereal disease (I trust eventually there will be no distinction in sex in this problem), all unmarried pregnant girls, all patients too poor to pay for medicine and apparatus, and all patients who need a different occupation. Personally, I have found the Social Service Department of especial value in presenting evidence, not merely concerning the home surroundings, but concerning patients with suspected drug habits and alcoholism and in the control of certain cardiac patients. In our Out-Patient Department the surest method of following up a patient and keeping him under observation and control is to refer him to the Social Service Department.

The Social Service Department, however, should be used not merely for investigation of certain social conditions and for the treatment of other social conditions, but it should be recognized as a separate department, a department which has cases turned over to it just as we turn cases over to any other hospital department. Social Service has a wider sphere of usefulness and can be of great benefit to the physician on broader lines. It is, I think, even to-day, a common misapprehension that patients who come to the hospital, whether to the wards or to the Out-Patient, always have some serious organic disease. As a matter of fact, this is not borne out by careful scrutiny of hospital statistics. For example, in 1910 and 1911 the Social Service Department and my hospital clinic, acting in co-operation, investigated medically and socially eighty working girls under twenty-one, who applied at the Out-Patient Department. A majority of the girls (forty-one out of eighty), had no organic disease which we could find. One half of these forty-one were diagnosed as debility. It is, therefore, evident that these girls came to the hospital for relief of symptoms that could not be relieved by the ordinary medical methods, but which might be relieved by various social methods. An analysis of these cases showed that to be true. Poor social

habits were responsible apparently for the symptoms in most of these forty-one girls.

The idea that a patient should be actually needy before being referred to the Social Service Department was seen to be incorrect from the study of these girls. The large majority of these girls received a wage, which, when added to the family income, seemed reasonably sufficient. The trouble was evidently not so much with the total income as with the intelligence with which that income was spent. Such a problem is surely a social and not a medical problem. Furthermore, I think you will all agree that a person may be very rich and yet sadly need some readjustment along Social Service lines.

In private practice a physician tries to do his own Social Service work. He usually does it very poorly. As a rule the physician of to-day does not have the intimate knowledge of the family life of his patients that your old-time general practitioner had. Furthermore, he has not the time or the training for social work. A conscientious physician would not undertake to practice any medical specialty with the little special knowledge and training that he has when he undertakes to investigate and treat the social specialty. I believe that we will have in the future social specialists or whatever you want to call them, engaged in private practice as well as in hospital practice. A clinic, whether dispensary or ward, that restricts the use of its Social Service Department to obviously needy persons is losing valuable opportunities for diagnosis and treatment in a large group of cases.

It is true that just as the symptoms of the patient often give no cue to his medical disease, so a patient's appearance may give no cue to his social conditions. It is now generally accepted that a periodic general physical examination is desirable for all persons. We try to make it compulsory in the schools. The same argument, it seems to me, should hold true of a social examination. At the Massachusetts General Hospital we have taken a few steps in the right direction by having social workers in some of the clinics. These social workers are on duty just as the visiting physicians. At the Lakeside Hospital in Cleveland they have followed this idea to its logical conclusions and a social worker meets every



out-patient case when he enters the dispensary. The argument is often made that patients come to a hospital for medical treatment and that it is meddlesome and objectionable to undertake a social investigation. Speaking from the medical viewpoint, far from objecting the patients in general seem pleased when once they have gotten over the surprise that anyone should manifest so much interest in their problems.

A recent casual survey of forty ward patients disclosed the need of the assistance of the Social Service Department in all but two cases. Investigation shows that a certain number of ward patients and a larger number of dispensary patients belong almost purely to the Social Service Department. Such cases should be referred to the Social Service Department for examination and treatment just as a skin case is referred to the Skin Department. The type of patient that especially belongs to this group is the man or woman that can best be described as a "square peg trying to fit into a round hole." Such a person is an industrial misfit. The original causative factors are often obscure. In some it seems to be heredity, in others it is poor home surroundings. It may be lack of education, it may be overwork, it may be plain ignorance or a combination of these factors. Such a person flounders about in our social scheme until some great break occurs. That break often sends the patient to the hospital. At this stage there may or may not be organic disease. Even if there is disease the social problem is the underlying and important factor. The obvious medical condition requires treatment, of course. If there is no medical disease, such a patient is a purely social problem. These problems are peculiarly difficult. The simplest part of the problem is the correction of an environment or the securing of a more suitable occupation. At the Massachusetts General Hospital we constantly refer to the Social Service Department patients who need better environment and a different occupation. We have not taken full advantage of our opportunities because it is usually the physically handicapped, either by paralysis, by the loss of a limb or by some serious heart trouble, for whom we are applying for lighter jobs. In our investigation we are able to find that a number of young women who might be considered to have good

positions financially and hygienically, really had very poor occupations from a social point of view. Most people take a job because it is handy and not because it is suitable. You have heard from Dr. Hall an account of the splendid work that he is doing in re-education. He fits a certain class of patients for a more suitable occupation. The interesting point is that Dr. Hall's solution of the problem while really along social service lines has achieved a remarkable therapeutic result from the medical point of view and was undertaken, I think, with the medical point of view chiefly in mind. Slowly this general idea is getting a foothold in all our hospitals. I need not dwell on the obvious therapeutic benefit from the clinician's point of view. It illustrates again how closely interwoven are the medical and social problems and medical and social remedies.

I have tried to indicate to you not only how the Social Service Department has been of tremendous value in the hospital in which I work, but also of the even greater opportunities if the social service is utilized as I believe it should be.

I think we are acquiring a new conception of the hospital. If one traces back the life story of the unfortunates of all sorts, one usually finds illness, often the hospital, as the turning point from the usual course of life of the afflicted person or his family. The hospital then should represent one of the main points of attack upon disease and misery of all kinds. It has other obligations than the perfunctory treatment of the sick. The hospital plays an important role in the furtherance of preventive medicine. But many patients in the hospital have no organic disease. The troubles of these patients are due to the complexities of our present civilization. It is obvious that such patients should be cured if possible. Social investigation also plays a role in preventive medicine. We want to relieve the present sufferers and to prevent similar suffering in the future. A large majority of all patients have a combination of medical and social ailments that are intimately associated, and in co-operation the investigation and treatment of the complicated situation should be undertaken by both the medical and social departments of the hospital.

## DISCUSSION.

PRESIDENT: Is there any discussion of Dr. Lee's excellent paper?

MR. M. M. DAVIS (Boston): I should like to dwell upon a subject that has been touched upon in the discussion tonight and suggested in Dr. Lee's paper, a subject which naturally interests every hospital superintendent who is more or less concerned with the problem of raising money, namely, the extent to which social service will have to be introduced. How much are we going to have to spend for it is a very practical question. Miss Cannon probably knows how many hospitals in the country have social service departments today, is it one hundred?

MISS CANNON: About one hundred.

MR. DAVIS: About one hundred. Probably a lot of those departments consist of one woman worker, that is true, is it not? That is of course a beginning. Now how far is this thing going to go? Each worker, as Dr. Warner has said, costs about twelve hundred dollars a year, with accommodations thrown in, and how much is this new and persistent and enthusiastic thing going to cost us before we are going to get through with it? It is a dangerous question, there is no doubt. When the social service department, as some one estimated tonight, will come along every year or four months with a demand for another worker, it places a heavy strain upon the financial ability of the hospital. That is a part of the larger question, namely, what is the real need of the hospital, with its out-patients and wards, for the kind of thing the social service can give? Dr. Washburn has said social service had been done before, there was a social service department, for the simple reason that the physicians had done their work long before social service ever was thought of as an organized thing, and physicians do their work well. It means that they themselves have done it through somebody else's social service. Now how far do the new conditions of modern life demand organized social service work by the social workers? The only way to study the situation in a given hospital and a given out-patient department. If a new hospital is beginning, it is certain it is first considering the kind of patients it will take, and it will study the extent to which social care, social investigation, social diagnosis is needed, as well as medical care, as well as medical diagnosis. That must be studied in a systematic, definite way. You must take a group of patients at random and study the kinds of needs they present. Miss Richards has suggested how a social survey can be made of a group of patients. It is possible to estimate in a given institution, roughly, but with a sort of degree of definiteness, how much social service is going to be needed. We roughly, taking one hundred or more patients, pick at random in an institution so many patients, estimate that probably seventy-five per cent. of those patients require more or less attention by a social worker, the other twenty-five per cent. probably would not need anything of that form of therapy.



Such studies are the only way, it seems to me, in which we are going to find what social service is going to be demanded in a given institution to find that thing out and then to get the money to realize that program as soon as it can. Just another thing in connection with this subject. Dr. Warner has suggested there are rather few things that appeal more to people than social service, and perhaps a persistent, annoying, but very useful stimulant of social service is not always a bad thing for the treasurer's bank account.

PRESIDENT: The subject is, What Can Social Service do for the Clinical Physician. I see Dr. Edsall in the rear of the room; can you speak on that subject, Dr. Edsall?

DR. DAVID L. EDSALL (Boston): I do not think I can add anything to what has already been said.

PRESIDENT: Is there any further discussion?

MISS CANNON: There are two or three things I wanted to have brought out before we left and one of those Mr. Davis has covered in the question of discrimination in the community as to what kind of things should be taken up. I think that we must also remember that there is something for the social worker to do in developing the resources of the community. I do not want you to go away tonight thinking that the social service department attempt to handle all the problems that come to us through physicians. Almost every one of the cities is very well supplied with various charities, various social agencies, and it is the function of the social worker to know those very well and to use them in the most helpful way. It is true, as time goes on, the agencies in the communities are going to know more about medical conditions, are going to understand better the physical side of things, and therefore we are going to be able more and more to hand over to them these problems that are sent to us. Aside from the development of those agencies outside, I think we are going to use more and more volunteers, we are also going to have more of the nurses' training schools who come to the department for social work. I think your training schools are going to be more attractive to the right sort of women when we give them the benefit of the connection with the department of social service. Last of all, I want to acknowledge the fact that we do recognize that we have not originated social service, but I want to tell one story. At the Massachusetts General Hospital, which was one of the institutions where the doctors were in the habit of doing social service work, a case was sent to our department, the doctor said: "I admitted this patient late, because she walked from Charleston. I gave her her carfare, but I should like to have you find out what the trouble is." The social worker visited the home, found the husband was earning \$18 a week, she found the woman very nervous and after considerable effort she ascertained the fact that the woman had an obsession about riding on the cars and she had not ridden on the cars for two years, not even after the doctor had given her the carfare.

PRESIDENT: Dr. Brown would like a show of hands as to how many here have social service departments in their hospital. (The result of the count was not announced.)

DR. PREST (New York): In passing, I wish to call the attention of this Association to the fact that the public health law of the State of New York today provides that each and every health officer of the state may employ a social service worker within the appropriation, showing that in New York State by statute we recognize the importance of this service. The words "Social Service Worker" are not in the present law, but the words "Public Health Worker," or "Visiting Out-Workers," or "Visiting Nurses," or "Social Service Worker," were in the original draft, but through lack of knowledge possibly of one that was close to the final passing in of the Act, the words "Social Service" were stricken out, but it was the intent of the Public Health Commission of that State to have it inserted and it has been so ruled by the Attorney-General today, showing New York State recognizes the efficiency of this service and its great value.

DR. FOWLER: I was commissioned some time ago by the city of Louisville to organize a large general hospital anew and I was instructed to visit every hospital in America, and I did so, that is, I mean, all the largest. I started out and travelled to the far West going to Los Angeles and up to San Francisco, then across the country from Seattle, Salt Lake and Omaha, to Chicago, and then finally to Boston, New York, Philadelphia, Baltimore, Cincinnati and home. One of the objects that I had in attending this Convention was to learn something about social service, because in the budget which I suggested, I suggested that we have a social service department attached to the new Louisville City Hospital, and the Chairman of the Board of Safety said to me: "Well, you can cut that out, there are too many nurses now falling over each other to earn their salary and doing no particular good." I asked him what he meant and he said: "Well, you have got your King's Daughters and you have your tuberculosis nurses and your settlement nurses and your school nurses, all under the pay of the city, we do not want to add any social service nurses to the City Hospital." I said: "Perhaps that is because you do not know anything about it," and then I set to work to prepare myself to educate the Board of Safety up to the standard of social service, and I found that more than two hundred years ago in the City Hospital of Paris, under Catholic supervision, that social service had been established, and later, some fifty years after, under Protestant auspices in the same city, and then it went to London, and then to Edinburgh, and then to Dublin, and then I think to Boston, if I mistake not, or it may be New York. I think everything good first comes to Boston. So in my travels over the country I asked the question, have you social service, and very few of the hospitals have it, but those that have it said they could not get along without it, and I can bear that willing testimony to the evidence given by the people whom I talked to. There is one trouble with us down in Louisville, we have not got a

social service graduate nurse anywhere within that region. I tested it out by an advertisement and then I sat down and wrote my friend, Dr. Winford Smith, and he referred me to his superintendent of nurses and she in turn, after some delay, referred me to Miss Brockton, and I never heard from Miss Brockton. I wrote to my distinguished friend here, the President, Dr. Washburn, and he referred me to his superintendent of nurses, and she to Miss Cannon, and Miss Cannon finally wrote me a very kindly letter giving her opinion, but I never yet have found a social service nurse that was willing to go to Louisville, and I should like to know in all seriousness if such a person can be employed and at what price?

MR. BORDEN: There are two or three things that make me want to trespass on this evening session. In the first place, to emphasize something that Miss Cannon has said, and in the second place to suggest a remedy for the difficulty which Mr. Davis has suggested about the cost, and in the third place to tell why our friend from the South has had his difficulty. I will begin with the last thing first. It is easily explained. There has been a lot of philanthropic endeavor through the communities for years, we are just beginning to find out that that philanthropic endeavor has got to be on scientific lines, and the reason my friend from Louisville cannot find a proper social worker is that there are not yet enough of them that know the business and it is time that we got them. It is a tremendous business, learning to connect the hospital with the community in a proper way.

To go back to the second proposition, about the cost. There again the philanthropic endeavor for years has been largely wasted because it has not been directed in the proper methods. We get a social service worker who understands her business and she is multiplied in her power and authority by volunteer workers who before have been shooting into the air, so that when we pay the salary of the social service worker we get out of the work of her hands and the work of her brain a multiplied work of many hands and many brains that have been directed in the wrong road previously. Now it seems to me there should be no question about the economy of social service work in the hospital. I am not interested in hospitals. I come here because there is such a nice company of people, I like to go to the meetings every year. I am interested in the community, and the hospital is one of the big machines that is going to better the community, and that is one of the other reasons why I come to these conferences, but the thing which is coming most insistently in the world today is to co-operate all the forces that are working for a better civilization, and the social worker is one of the tremendous connecting links between the machines that have been working at odds heretofore.

PRESIDENT: I think that hits the nail pretty nearly on the head. This is an age of social service and an age of efficiency. Is there any further discussion?

MRS. LEWIS: This gentleman has just touched a point which is becoming very much emphasized with the outside charities,



outside of strictly medical social service in large city hospitals. I think we as social workers in the field of organized charities are coming to feel that medical social service is to be the foundation of good organized charity, and I want to speak just a word tonight in favor of the small city hospitals. You have been talking all through this Convention, as near as I can learn, about the large city work and yet I know that there are a great many nurses in the city from the small cities throughout the country. Through the American Association of Societies for Organizing Charities we are trying to organize social work in every city in America of over ten thousand people, ten thousand and over, and the societies are growing very rapidly in number. Many of our workers have no medical social training whatever, very few comparatively, and that is the point I am trying to bring out, that we are coming to realize that every charity organization secretary at least should have medical social training, and she must be in a position to stop her work for some length of time, several months at least, and take this training in some large city hospital social service department. I just want to say a word or two in regard to the work we are trying to do at Newburyport, which is near Boston, and the resources of Boston are our resources, and because the secretary there has had some social training, she has realized the good which is coming through the social service department of the town, and the number of patients which cannot be cared for because of limited equipment are being referred to the Massachusetts General Hospital. For instance, one of our physicians came in touch with one of our shoe factory employes, who had a very common case of goitre, but was very nervous and distracted and hardly knew what to do, and finally became very unhappy over the attitude of the physician toward her, and he appealed to the charity organization and said, "Can you go down there and make this woman understand that I am working for her good, and while she may not be able to have her goitre removed at the small hospital, perhaps you can persuade her to go to Boston." When we went to investigate we found she had no means with which to go to Boston, that it would cost her something, she thought, to have the operation, and so we were able through a person who was interested in our social work to have an appeal made to the Massachusetts General Hospital for a free bed for this woman, and this man also volunteered that all her expenses coming and going should be paid, so she was brought to Massachusetts General. Then they asked the social department of the Massachusetts General to take a special interest in this patient and they have visited her every few days and sent reports back to her daughter and we have been able to see her ourselves. We find her very happy in mind, she had the operation performed during that time, and I saw her this morning and she said, "It is wonderful the friends we find when we need them." So we feel in the small cities that we are dependent on the social work in the large cities and the influence is being felt throughout the country.

PRESIDENT: If there is no further discussion, the meeting is closed.

**FRIDAY, AUGUST 29—MORNING SESSION.**

**PRESIDENT:** The Convention will come to order. We will listen to the report of the Special Committee on Bureau of Hospital Information. Dr. Winford Smith is not present, and the report will be presented by Dr. Hurd.

**REPORT ON PERMANENT BUREAU.**

To the American Hospital Association:

Gentlemen,—When the Special Committee on Bureau of Hospital Information was appointed we found that the previous Committee had succeeded in having introduced in both Senate and House a bill for the establishment of a Bureau of Information on Hospitals under the Public Health and Marine Hospital Service. No hearing had even been granted on the bill.

Through Senator Fletcher, sponsor for the bill, a hearing before the Senate Committee was granted and held during the last session of the previous Congress, Drs. Hurd, Goldwater, Smith and Skinner, members of the Committee, all being present.

The Committee was well treated and felt encouraged by the attitude of the members of the Senate Committee. It was however pointed out by Senator Williams that the bill under consideration was unnecessary inasmuch as the Public Health and Marine Hospital Service already had sufficient power to do this work. Senator Fletcher afterwards informed the chairman that Senator Williams was right and that another bill should be substituted authorizing sufficient funds for the purpose.

In reply to repeated requests for action Senator Fletcher has said that it had been difficult to find the proper opportunity to introduce the substitute bill but that he would do so as soon as possible. That is the situation at present.

Your Committee would therefore report progress and recommend that a new Special Committee on Bureau of Hospital Information be again authorized and appointed at this meeting.

Very respectfully submitted,

WINFORD SMITH, Chairman.

## DISCUSSION.

On motion of Dr. Fowler the report of the Committee was adopted.

PRESIDENT: At the last Convention it was voted that the Executive Committee be instructed to procure an act of incorporation, preferably in the District of Columbia, and as soon as that was procured to take the necessary action to prevent the use of our name. That was because certain parties in Chicago were using the name of the American Hospital Association for advertising purposes. This matter has been taken up with the Executive Committee and Dr. Howland, member of the Committee, will make this report.

DR. JOSEPH B. HOWLAND (Massachusetts General Hospital, Boston): The Executive Committee consulted a reliable lawyer in this city with a view of the incorporation of the Society. He advised us at the time that incorporation would not in any way protect us, that the only way we could overcome the use of our name would be to bring proceedings against this individual in whatever State he used the name and he was not sure that that would do it. As this association, American Hospital Association of Chicago, was located in that city, he turned the matter over to a prominent lawyer in that city and he reported back that after considering the matter and investigating it, he did not consider that we had any case, that it was not a competing concern at all, merely using that name, cited many cases to show that in his opinion we could do nothing. He had consulted with the local attorney and they thought it was best for us to drop the matter. The Executive Committee decided that it was a matter of law, that we were not lawyers, therefore we had better take their advice, and therefore we decided to recommend to this Association that nothing further be done. The President suggests that perhaps I did not make clear that incorporation is not a national affair and that incorporation in one State is not any protection in another State. That is a fact.

PRESIDENT: You have heard the report of the Executive Committee on the question of incorporation, what will you do with it? It has been moved and seconded that the report be adopted. All in favor signify by saying aye, opposed no, it is carried. We now come to the paper of this morning session.



## REPORT ON HOSPITAL FINANCES AND COST ACCOUNTING.

BY WILLIAM O. MANN, M.D.,

Superintendent Massachusetts Homeopathic Hospital.

The subject of hospital finances and cost accounting has been so thoroughly covered at previous meetings of this Association that I feel that very little can be added to what has already been written.

The New York hospitals, a number of years ago, adopted a system of financial accounting which has been copied by numerous other institutions, so that there is now an opportunity among the larger hospitals to make a comparison between the costs of different departments.

Some institutions have attempted to ascertain the detailed cost of each department, for instance, the cost per 100 pieces in the laundry; the cost of feeding a nurse as compared with one of the help; the cost of feeding a private patient as compared with a ward patient. I can see that this may be a good thing for the individual hospital to check up the detailed cost from month to month and from year to year, but I do not believe that it follows that because one hospital can do a certain thing at a certain cost, that the one across the street from it can do the same thing.

Some hospitals cater to a large number of paying and private patients, while others cater to only the free class, as in a municipal hospital. It stands to reason that the food cost in the smaller semi-private hospital is larger than in the free hospital; that the nursing cost per day will also be larger, because the paying patient and private room patient demand and receive more than the free ward patient. I believe in a system whereby one can know the monthly cost per patient and the monthly cost of food per inmate. If this is done, one can check up with the preceding months and the preceding years and make comparisons with his neighbors.

It is well to make a check on the laundry, because if one finds that it costs \$2.50 per 100 to do the laundry in the institution, while it can be done outside for \$1.50



per 100, it seems poor business policy to continue to maintain a laundry. The large commercial plants now have the laundry business down to a science and are in a position to do it fully as cheaply as an institution can do it.

At the Massachusetts Homeopathic Hospital, we try to check up the cost of different articles by months and years and we use what we call a comparative expense book for that purpose, an illustration of which is before you. This book has a column for practically every item that is purchased. Each column shows the months of the year and has a space for four years opposite each month. You thus have the comparative cost or comparative amounts of supplies before you for four years. It means about an hour's work for two people once a month to analyze the bills. The per capita cost is figured every month and the food cost per inmate is also figured monthly and placed in this comparative expense book, where it is easily available.

We consider this book a valuable one, as we are able from year to year to compare the cost of the different supplies and to know whether or not we are becoming more wasteful or more economical.

We also have simplified charging supplies to the different outside departments and to the wards. One requisition weekly is originally made out by the head nurse, or the one in charge of a department. You will notice by the illustrations before you that there is a column for quantity, one for the name of the article and a dollar and a cent column. These requisitions are approved by the Superintendent and sent to the proper department to be filled. After they are filled, they are returned to the office, where a clerk prices up the articles and totals them at the bottom. They are then filed and at the end of a month, the totals are added together and each department or ward is charged with what has been furnished. This system saves a great deal of duplicate writing and we find it very simple and requiring no extra labor.

During the past summer, we have been able to figure the cost of our laundry and we find that by including the wages of employees, the board of employees, electricity, gas, steam, water, insurance and depreciation, that the cost per 100 pieces is \$1.34.



At the Massachusetts General Hospital, the cost of the laundry is \$1.29 per 100.

At the Massachusetts Homeopathic Hospital, we have for a number of years used voucher checks in paying our bills, which means that we do not require receipted

HOUSEKEEPER				MASS. HOMŒOPATHIC HOSPITAL			
FOR 4 <sup>TH</sup> MED.				DATE JULY 1 <sup>ST</sup> 1913			
QUANTITY	LINEN	UNIT	PRICE	QUANTITY	DISHES	UNIT	PRICE
6	Bed Protectors		3.00	6	Bowls, Soup		.95
	Blankets				Bowls, Sugar		
12	Chinamen		6.45		Butter Chips		
	Mattress Covers			4	Cocoa Pots		1.17
	Napkins				Cups		
6	Pillow Covers		.87	8	Egg		
	Pillow Slips				Glasses		.44
	Pins				Glasses		
4	Rubber Sheets		3.00	10	Plates B & B		.96
	Safety Pins				Large		
16	Sheets		10.04	6	Small		.67
	Spreads				Pitchers		
12	Towels, Bath		2.50	3	Salt Shakers		.39
	" Dish				Sauce Dishes		
18	" Hand		2.18	13	Saucers		1.03
	Tray Cloths						
	Wash Cloths						
			<u>27.84</u>				<u>3.61</u>

Requested by \_\_\_\_\_

Approved \_\_\_\_\_

OLD OR WORN OUT ARTICLES MUST BE RETURNED

bills from the firms we deal with and this system is being adopted very generally by other hospitals, I understand.

We have also found that by discounting the bills on a ten days basis, we have made a saving in the year 1912 of over \$800.

At the Presbyterian Hospital in the city of New York, they have adopted a system of order requisitions, receipts for supplies and material and store-room requisitions, which are along the line that I have mentioned that has been carried on for some time at the Massachusetts Homeopathic Hospital.

From Dr. W. H. Smith, of the Johns Hopkins Hospital, I have received the following:

"We are installing a cost clerk, who will be located with the chief store-keeper and by whom all requisitions will be charged up against the various departments of the hospital, including food. That is, the raw material, such as eggs, milk, etc., which is sent directly to the wards and other departments. Meats and other foods sent to the main kitchen will be charged up pro rata. The nurses' home, having its own kitchen, will be charged directly for everything it gets. I feel that by this system of charging directly to each department, everything except the cooked food and charging each department pro rata for the number of people in that department, either employees or patients, we will have eliminated as much of the guess-work as is possible and that we have brought down the question of cost accounting to a practical basis without carrying it too far, which I think would happen if we attempted to gauge the prices of the various cuts of meat going to the different departments and to weigh out the vegetables, etc., from the main kitchen."

Dr. Howland at the Massachusetts General Hospital, writes as follows:

*"Bills Payable.* Bills are paid as heretofore at various intervals during the month in order to take advantage of the discount offered by dealers for prompt payment. In the past, a recapitulation of all bills paid each dealer each month was made on a form of voucher and this voucher sent to the dealer at the end of the month to be receipted and returned, after which it was filed with the bills as evidence of payment.

These vouchers were frequently held by the dealers and this made it necessary to write for them in order to complete the files. Preparing and mailing these vouchers together with checking their return consumed considerable time and also cost the hospital about \$5.00 a month for postage. These vouchers have now been

abolished as entirely unnecessary thus making a saving in labor and about \$60.00 a year in postage. The cancelled check is now considered by the leading business houses as sufficient receipt.

STORE ROOM MASS. HOMOEOPATHIC HOSPITAL		
FOR 2 <sup>ND</sup> SURG.		DATE
		JULY 1 <sup>ST</sup> 1913
QUANTITY	ARTICLE	PRICE
12	Yellow Soap	24
6	Green Soap	09
12	Toilet Paper	72
3	Wet Mops	63
		<u>1.68</u>
REQUESTED BY		
APPROVED		

*Bills Receivable, Patients' and Doctors' Accounts.* All money from whatever source passes through the



hands of the cashier and by her is distributed on a daily sheet to the various departments to which it belongs. This sheet is balanced each day and a bank deposit slip to correspond in amount with the daily sheet is made.

A petty cash fund is carried by the cashier from which are paid all small cash bills which are presented at the office. This fund when depleted is made good by check and entered in voucher register as any other bill. This method reduced the petty cash entries from 100 to 125, down to 4 or 5. A receipt is now taken for every cent paid out and these are filed with the bills.

*Pay Roll.* This was formerly handed in on the morning of the 27th of the month by the heads of departments who anticipated that everyone would work the remaining three or four days. In the event of anyone being absent after the payroll was handed in, a slip was sent to the office stating that the employee had lost time beginning at a certain time. If this employee returned to work again before the first of the month, another slip was handed in showing the time of returning to work.

The names of employees were all copied from the sheets received from departments onto another sheet, on which was entered the total wages due and this sheet was signed by the employee.

Our new sheets are filled in by the department heads showing the name, position, days lost, days employed and rate. The total wages are figured in the office and entered directly onto the sheets received from the departments. This saves copying over 400 names, which in itself takes considerable time. The payroll is now handed in the last day of the month, which does away with the numerous slips concerning lost time.

The information contained on this sheet regarding days lost and employed, deductions, etc., is of much assistance to the paymaster, as he can readily make explanations to any employee who believes that his wages are incorrect, where formerly it was necessary to send them to the office for explanation.

*Journal and Ledger Accounts.* The journal entries have been abolished as serving no useful purpose. Ledger accounts which were kept with the various items shown on the financial statement and which are

used solely for the purpose of getting a trial balance every quarter have been discontinued, and in place of these a recapitulation is made in the back of the debit cash book and voucher register."

At the Massachusetts Homeopathic Hospital, we have also come to the conclusion that these journal and

DRUG ROOM MASS. HOMOEOPATHIC HOSPITAL.		
FOR 3 <sup>RD</sup> SURG.		Date JULY 1 <sup>ST</sup> 1913
QUANTITY	ARTICLE	PRICE
12	lbs. Cotton	1 98
200 yds.	Gauze	4 50
4 qt.	Peroxide	35
2 qt.	Alcohol (Bathing)	50
6	Rectal tubes	1 58
1	Hypoderm. Syringe	87
6	" needles	50
		<hr/> 10 28
REQUESTED BY		
APPROVED		

ledger accounts are of no use and we have done away with them.

It is well for every hospital to adopt a simple form of cost accounting or comparison of costs of different articles purchased, in order that they may know just how much they are spending for each item and in order

that they may compare the cost of these items with what other hospitals are doing. If one hospital finds for instance that the medical and surgical supplies per patient are costing more than at several other hospitals, it is wise to find out whether the buying is not being done at a disadvantage, or whether the supplies are not being used too generously. This is a comparison that should be made, I believe, by every hospital, annually, in order that they may know just what they are doing.

One can readily see that the cost of heat and light will vary according to the construction of the individual hospital. A hospital on the pavilion plan will cost more to heat than a hospital built on the block plan, but with the medical and surgical supplies, laundry, housekeeping supplies, etc., a comparison can easily be made.

For anyone who is interested in the detailed accounting of each department, I wish to refer to a book just published during the year 1913, "Cost Accounting for Institutions," by William Morse Cole, assistant professor of accounting in Harvard University. This book goes into detail and shows a very elaborate system of cost accounting. Personally, I do not believe that it is necessary or wise to go into this detail, because the results obtained do not affect the extra cost of the book-keeping and clerical hire.

## DISCUSSION.

PRESIDENT: Dr. Mann's report is before you for discussion.

DR. JOSEPH B. HOWLAND (Boston): Dr. Mann and I visited institutions some time ago to learn something about cost accounting, and we found in some hospitals that cost accounting was the principal thing, the whole hospital was upset by the amount of recording in all departments necessary to keep cost accounting. Apparently that was the one thing that the institutions thought of. Everybody dreaded it, everybody hated it; it was started a simple thing, but it became more and more complex, until the one thought and aim of the hospital was to have a perfect cost accounting. I think they may have had it, but they did not like it.

PRESIDENT: I found in attempting to get at cost, that it is very difficult to get units which are comparable, one institution with another. If you think you have got it, you have made a tremendous amount of work, there are still a lot of things to be



explained. If in our laundry it costs a cent and a third apiece, and if in Dr. Mann's it costs a cent and a half or a cent and a quarter—I like to quote that, because that is the only thing we do cheaper than Dr. Mann, he runs his business mighty well—if that is so, why then you go down and investigate and you will find some mighty good reason for it. You will find that there are ifs and ands and things to explain. But what appeals to me as of very great value is to get your costs in one of your own departments every now and then and check up what you are doing yourself year by year, whether you are increasing or whether you are decreasing, it gives you an opportunity to put your finger on waste. We do not attempt in our laundry or our surgical building or our kitchen or wherever we are trying to find our costs, we do not attempt to continue it throughout the year, it means too much bookkeeping, but we do take it every little while. We put in a meter and measure our electricity, put in a meter and measure our water, and do it for a week perhaps twice a year, we have our pipes arranged so that we can do that, and then that gives you an opportunity to check up and see if you are wasting such things and at the same time we carry cost accounting right through that department. There is something that you can do which is very valuable to you in your own institution, but theoretically we ought to be able to do the other. We ought to be able to reduce our X-Ray to the cost per plate or the cost per patient, whatever you pick out as a unit and compare with the other fellow, and if it is costing you more money, why then it is wrong, but practically it does not work out that way, because there are so many ifs and ands. All these experts on accounting tell me I am wrong, we ought to be able to do it, I suppose I am.

DR. JOHN M. PETERS (Providence): A good many superintendents of institutions take great pride in keeping track of their per capita cost of food, and I have often wondered whether it is worth while. Personally I am not strictly proud of showing a low per capita cost of food, unless I know what food has been given. I think it is a hard thing to compare cost of food per inmate with that of another institution, unless you know what that institution is feeding its patients. If any institution is honestly managed and waste is stopped, I think a rather high per capita cost of food is in favor of the institution rather than a low cost of food. There is one question I should like to ask about the pay-roll whether any of the institutions have done away with the signature of the pay-roll by the employees. We have taken up that question now. It has been recommended that it be not necessary for employees to sign the pay-roll, but the pay-roll is made up by the heads of the departments and endorsed by the head of the institution, the pay is put in the envelopes and given to the employees as they do in large corporations, hotels, factories, railroads, no receipt is taken. They say if there is any loss, or full amount is not given, objection will be made at once and that the thing will be straightened out then. They say with the number of signatures that are necessary in the large pay-roll, that the signature is practically useless, anybody could forge that signature.

I should like to know what is the custom in some of the large places.

DR. CHARLES A. DREW (Worcester): Some five or six years ago in Worcester there was a company employed to institute the cost account system in the City Hospital, and while at first it was thought troublesome because it took time to weigh articles of food over a period of days and it made a great deal of extra work and took extra time, I think we have grown to feel that it is a good thing all around and it not only enables us to compare our costs each year, but it enables anyone under the city government trustees to look up information. It is not perfect, and I do not suppose any system will be perfect, but we not only want to do things as well as we can, but we want to be able to prove that we are doing things reasonably well. We like the system and think it is worth while.

MR. CODDINGTON: I should like to ask Dr. Washburn if he makes these tests that he spoke of at certain months from year to year, or whether they are at irregular periods, and also if the employees of the department know that you are making the test at the time you are making it. In regard to Dr. Peters' inquiry with reference to receipts, I would state that the hospital with which I am connected at Philadelphia, we are compelled to take receipts by the State, we receive a State appropriation, but I have always disapproved of taking a receipt on a sheet and having one after another become familiar, as they can at a glance, with the amounts that others are receiving, so I have discounted the sheet receipt and have a printed form and individual receipt printed in such a way that there are only two or three little items to be filled out. That is taken from each individual and filed with the pay-roll.

MR. W. B. SOUDER (Philadelphia): For a small hospital I think that the system that we have at the General Homeopathic Hospital is about the best we can get for a cost system. It is a sort of a cash book comparative cost system where we can from month to month compare each department with the previous month. It is a very simple arrangement, it is all done in the open book and does not take up much time. Of course it takes a great deal more addition perhaps that it would if we did not keep it. It is a regular comparative cost cash book. At a glance we can tell what each department receives, in the same way just what we receive from the different departments, say the ambulance and operating rooms, sanitary supplies or donations, anything of the kind you can tell at a glance comparing month to month. If any one would like a copy of that form I shall be glad to send them some blank sheets. We can tell from month to month whether we are increasing a department or decreasing in regard to the number of patients, we can make a comparative estimate on the first of the month, or even in the middle of the month.

MR. H. E. W. SIMON (German Deaconess' Hospital, Buffalo): In regard to the matter of pay-roll in our institution for two years we have not required the signatures of employees, first for the reason that they need not know what others are getting,

and for the second reason that it saves time in paying. We pay twice a month, on the 5th and on the 20th of the month. The reason for that is that we have had some difficulty with some of the employees taking advantage of us. In this way we always hold five days' pay on them and we have the whip hand. I think we are not required, because we receive no State aid, to take any other kind of receipt. We simply take receipts in that way and it has worked very well and we have not had one instance where there has been any difficulty in regard to the amount of money paid.

DR. HOWLAND: We recently had passed an Employers' Liability Law in this State. Very recently one of our employees was injured and after the two weeks, according to law, in which he received medical care, he then was entitled to compensation by the insurance company. He told them that his wages were, we will say, \$40 a month, while as a matter of fact they were something like \$25. He expected to get one-half of \$40, instead one-half of \$25, he thought it would go through. The authorities wrote to ask what his wages were and I told them. He still declared that I was mistaken, so he came down with the insurance people and I let him see the pay-roll, showed him his signature, \$25 a month. I don't know whether that answers Dr. Peters' inquiry or not.

DR. KAVANAGH: I should like to ask if that particular employee boarded in the hospital.

DR. HOWLAND: He did.

DR. KAVANAGH: Did he not have a right to add something for his board?

DR. HOWLAND: The information was given the insurance company that that was \$25 plus board. His information was that he received \$40 cash plus board. That was taken into consideration.

PRESIDENT: Any further discussion? Is Dr. Young here? Has Dr. Young delegated any one to read his paper? Perhaps Dr. Young may come later, he may have been delayed, his paper may appear.

A MEMBER: I had a telephone talk with Dr. Young day before yesterday and he said that he had not had an opportunity to prepare his paper and that he was going to write you to that effect.

PRESIDENT: I have not been in my office for several days, there may be a letter from Dr. Young.

It gives me pleasure to introduce to you your President-elect, Dr. Howell.

DR. THOMAS HOWELL (New York Hospital, New York City): I assure you that I appreciate the honor that you have conferred upon me by electing me your President. I shall try to discharge the duties of the office in a creditable manner. It is a very hard position and I should not have thought of accepting it if I had not believed that you would all turn to and assist me in making the 1914 Convention a success. I thank you.

We will now proceed with the Question Drawer.



## QUESTION DRAWER.

PRESIDENT HOWELL: We are fortunate in that a large number of excellent, practical questions have been handed in for discussion; we are fortunate in that the time allotted to the Question Drawer is limited. I would ask that the responses be prompt and that the discussion be as brief as possible.

Question No. 1.—*What is the best method for getting good medical and surgical records? Who should write the records? Who should dictate them, and who should inspect?*

DR. HURD: This whole question I think depends very largely upon circumstances. In the small hospital where there is no resident medical officer, where it is difficult for the medical man, who frequently serves the community without any compensation and at very great inconvenience to himself, I think the medical histories should be taken by a nurse, the head nurse, or the superintendent of the small hospital. In the large hospital, where medical history is very important, frequently is connected with medical teaching, it is most important that the history should be taken by the physician. I will say, as a general rule, that a physician ought to take the history, because it is as much a professional matter as the diagnosis of the disease and of the treatment. The physician should take the history. Now whether he should write it down himself or whether he should dictate it to a stenographer, is a matter which largely depends upon the means which the hospital has, and also upon the facility of the medical officer to do the dictation. Some people are very fond of dictating and have great facility for it. Other people seem to be more capable of using their minds with a pen in their hand. I once heard a discussion between two very eminent medical men as to whether there was going to be any improvement during the next half century in the rate with which we did our thinking and these gentlemen agreed that formerly the majority of people did not do any thinking until they sat down to write it out, and the speed with which they thought was gauged by the speed with which they could record. Under the use of the stenographer and the dictaphone and so on it is possible to transcribe your thoughts more rapidly and consequently it is possible to think more rapidly. I do not know whether there is something in that or not, but I have noticed that the tendency on the part of the records which are dictated is to give a great deal of verbiage and a large amount of material which does not amount to much. Personally I prefer to have the history by a man who writes it down in his own hand and therefore chooses his words and selects his phrases better. Therefore I would say that the man who takes the history should either write it down or dictate it and should afterwards read it over carefully. Then the question comes who should inspect them. There should be

in every institution some person whose duty it is at regular intervals to inspect systematically the medical records of institutions. I have been filled with wonder and amazement often with confusion in going over very elaborately kept histories up to a certain point, and we frequently find a record like this: "Patient is very much better today," then a long lapse of time and then perhaps "Died a month afterwards." The patient ceased to be interesting, and then there was a gap that had to be filled up, frequently that gap is never filled up. The only way to avoid that is to have some one regularly, at least once a week, go over the records to see whether they are carefully registered. Although the question does not come up here, I will make one additional statement. It seems to me extremely important that all histories should be carefully inspected by the medical staff together, that there be a joint meeting to look over the histories and to see what is put down, with all the symptoms, then determine and agree upon a diagnosis. That is equally as important as inspection.

PRESIDENT: Has any one else anything to offer on this subject? It is an interesting and important subject. Dr. Hurd certainly discussed it very thoroughly. I believe some of the institutions are beginning to use the dictaphone in their record work. We are using it in our operating room. I noticed that the Peter Bent Brigham has a dictaphone in the operating room.

DR. HURD: Perhaps I ought to say in answering the question that has been asked me just quietly, I would not have a gathering of all the physicians in the hospital to look over the histories but there should be a consultation of the physicians in each department. For instance, medical histories should be considered by the medical men, surgical histories by surgical men, and so on.

Question No. 2.—*Now that the various states of the Union are passing laws governing training schools and practice of nursing, and are establishing by these laws the minimum preliminary educational qualifications, does it not seem just that they should establish a lower standard than one year in High School? In view of the fact, that owing to the great increase in training schools there are not enough women with High School education to fill all the positions, and in view of the further fact, that many women with common school education make excellent nurses, why would it not be better for the states to provide a minimum requirement of a common school education? This would give the schools a wider range of selection and enable them to train more nurses. Each school could fix its own standard of preliminary education, providing it was equal to or higher than the standard established by law.*

DR. DREW (Worcester): If I had the eloquence of Bro. Kavanagh or if I could hold to my theme like Dr. Goldwater, I would not take the trouble to put my remarks on paper. Indeed, I am not sure but that I would leave the medical profession altogether.

I heard a story of a preacher who was a candidate before an unusually large audience. This story warned me not to take chances. The preacher trusted his memory and closed his sermon something like this: "I say to you as the Master said to His disciples of old: Go to the lost sheep of the house of Israel, heal the dead, cast out the sick and raise the devil."

This is not a question that is easy to handle because it has been handled so much that it generates heat. If I were in politics I would side-step. If I were a candidate for anything in a state sufficiently enlightened to have equal suffrage regardless of sex, I wouldn't touch this question even to please my friend, Dr. Howell. But I am not in politics that I know of and Dr. Howell has asked me to discuss this question. I don't like to show the white feather, so what can I do?

I do not like the form of the question because it reads as if the man who asked the question was telling us how to answer it. For many years the medical profession, as represented by state and national medical societies, has tried annually and strenuously to raise the bars higher and higher to keep out of the medical profession applicants who have not enjoyed the advantages of a liberal preliminary education.

For a comparatively few years the nursing profession as represented by state organizations of nurses, has tried to bar out of the profession of nursing those who have not had at least a preliminary high school education. In the one profession an academic college degree has been the standard hoped for. The other profession has hoped for a standard not lower than that represented by a high school diploma. The object of the advocates of higher standards in both professions has been the public good and the exaltation of the profession. It might be fair to say the public good through the exaltation of the profession. While it is granted that a college degree is no guarantee that the man has clean hands and a pure heart, it is admitted that the holder of such a degree has at least been associated with and presumably influenced by scholarly and altruistic men. So it is held regarding a high school diploma, which does not guarantee that the girl is sympathetic or tactful or even honest. Many experienced educators believe that a girl with less than a high school education cannot grasp the principles nor digest the instruction which good schools try to represent and teach. A few of the more favored hospitals, with means to attain approximately their high ideals, have no difficulty in finding a sufficient number of candidates with a high school diploma. It is often assumed in discussion that the reason all schools do not have plenty of high school and college bred girls on the waiting list, is because their standards are low. It seems probable that if all schools were equally heavily endowed and equally well equipped, the shortage would simply be more evenly distributed.



It is against the evidence to assume that there are enough high school graduates with the high idealism of Miss Riddle or with the matter-of-fact report of the majority of the committee. It is against the evidence to assume that there are enough high school graduates to supply the demand of the fast multiplying hospitals and the fast growing demand for nurses in social service schools and other kindred lines of work. To use a much "worked" quotation—"it is a condition, not a theory"—that we are up against. In spite of the many hospitals, Mr. Bradley tells us in his excellent paper of Tuesday that 86% of the sickness in America is in the home, and the evidence seems to prove that the homes of the self-respecting middle class are woefully short of nurses.

I regret very much that the thoughtful papers of Mr. Bradley and Miss Riddle could not have had a free discussion on Tuesday afternoon. There are many members of this Association who would like to hear the evidence and the arguments for and against the classification and grading of nurses which is very closely related to this question of preliminary education.

Whether we agree with the high idealism of Miss Riddle or the matter-of-fact report of the majority of the Committee, this Association as a whole, in my opinion, suffers a distinct loss in the side-tracking or the postponement of the discussion of these two valuable papers read Tuesday afternoon. I was so much impressed that I dreamed of those papers Tuesday night. But things were badly mixed as they often are in dreams. In my dream I was sitting with this Association in this same hall but instead of the reader of Tuesday afternoon a handsome general of the United States army in his uniform had the floor. His paper was a plea for raising the educational standards in the army. We argued that we would have plenty of educated men apply if we closed the doors to the uneducated. His slogan was: "The best is none too good." I dreamed that we were all wildly enthusiastic and under the spell of his eloquence we voted unanimously that no one who had not at least one year in West Point should be admitted to the U.S. army. Judging from my own experience, I see no need of legislation to fix a standard of education for probationers. I am inclined to think that a Training School Committee of the trustees and the superintendent of nurses and the superintendent of hospitals are, as a rule, fairly well qualified to judge after a six months' probationary period, who are and who are not fit to continue in training.

Again, my experience and observation forces me to believe that the question of a college or high school education depends very often on the financial condition of the parents. I know many men holding positions of honor and influence in the Commonwealth who went to work directly after leaving the common school. I do not doubt that there are thousands of bright girls who are well fitted for all the practical duties of nursing, that are forced by circumstances to go to work directly after leaving the grammar grade. We need many broadly educated nurses for teachers in our hospitals, for leaders in social service and for private nursing in many cultured homes, but I suspect we are laying too much stress on education as obtained in the schools

and attaching too little importance to constitutional and temperamental fitness and that education which is obtained in the school of adversity and necessity for self-support. Lest I be misunderstood, let me say that I have no grouch against the high schools nor any higher institution of learning. I wish it were possible that every son and daughter of our great country could have broad educational opportunities as well as good food and good clothes and time to play. But because thousands of boys and girls with keen perceptions, sound nervous systems and honest ambition for self-betterment are denied such opportunities and such luxuries, I see no good reason why we should shut the door of opportunity to him or her who is not born to be fed with a silver spoon. My plan would be to judge each case on its merits. Secure a personal interview with the candidate if possible. If the superintendent of nurses is in doubt the superintendent of the hospital should also see the candidate, then submit the application in the candidate's own handwriting to the trustees—or at least to a committee of the trustees—with such recommendations and evidence of education and fitness as the candidate may be able to furnish. If the superintendent of nurses approves and the trustees concur, open the door of opportunity, give the candidate a chance to show her fitness whether she has entered the high school or not, providing she did not drop out of school from choice rather than necessity.

To my mind, the time to weed out the unfit is during the probationary period. A good instructor of probationers and a competent fair-minded superintendent of nurses should be able to decide during a six months' trial, whether the girl is possible or not. In many cases the question is clearly settled in less than three months. If there is a doubt, a longer trial should be given. If a competent superintendent of nurses is not supported because of misdirected sympathy or because a nurse has a pull, woe to the school. If the superintendent of nurses is not fair minded and competent, woe again to the school.

DR. COOK: I wish to raise just one question, or make one point. To establish by law a minimum of one year in a high school, or two years in a high school, you must show that you are better protecting the State by that method, because it comes under the police power and the police power has to do simply with the protection of life, health and property, therefore it is essential to show that to keep out all the young women who have not had a high school education or one year in high school, will protect the life or the health or the property of the commonwealth, and I have a suspicion that it would be rather difficult to prove that and when you have established the law doing that you have interfered with the right of the individual to get a living. I want to give you the decision of the Supreme Court of the State of Massachusetts in the neighboring city of Cambridge, where a man was refused a license as an undertaker because he was not an embalmer. The case was carried up to the Supreme Court and the Supreme Court ordered that license to be issued. Why? Because embalming was not essential to the protection of public health; therefore, because embalming was not essential, but was a matter of choice in each case with

the friends, they ordered that license issued because refusing of the license was interfering with that man's rights, and the license had to be issued,, and in any given case when anybody wished the embalming of a body, he could call in an embalmer. Now the question I leave with you is whether to say a girl who has not a high school education cannot be a nurse is protecting the public health, the public welfare, and if it is not protecting it, if it is not dangerous to let that girl become a nurse, then she should have the right to earn the money. If that case were carried up in the courts it is a question in my own mind whether the law would be sustained.

DR. KAVANAGH: Last year, 1912, Miss Nutting wrote a paper on State Education of Nurses for the general government. I read the paper at the time and was greatly interested, and read it later, because it contained some facts that were well worthy of consideration, coming from a person of such eminence as a leader in the work of the education of nurses, and so on my way up here, although it is a year since I read the article, I put the article in my valise and on the train again looked it over, and for the first time studied the very elaborate statistics that were collected by the government—I do not think collected by the state, but collected by the government in regard to the eleven hundred schools in the country that were registered. I am frank to say that on my way from New York I did not have a chance, as I got into the thing, to carry it through a thorough investigation, such investigation and analysis as I wanted to make of those statistics, but I found some things that were very interesting and very suggestive. I want to give you three or four of those statistics because I think they have a bearing on the subject before us. In New York State 124 schools reported training schools of the different hospitals. Of course you know in New York State the preliminary requirement is one year high school or its equivalent, then your hospital can make a condition of two years, three years, or the whole high school if they wish. I found that in New York State of the 124 schools, eight schools had made a preliminary requirement of high school and had a perfect right to do it, but of those eight, one of them had seven nurses, two of them had ten nurses, I think, one of them 18 nurses, and one 24 and one 40—two large hospitals with 113 nurses and 125 nurses respectively, so that you see that two or three of these would scarcely count in furnishing any proof as to what they should do about this thing one way or another, but in the 124 schools in New York City, we will say half a dozen fairly good-sized hospitals, two of them very large hospitals, had established for themselves the preliminary high school condition. Now as I stated, and I was studying this without looking to prove anything, I am simply looking the thing over, and this thing appeared to me as a point that I had never thought of before—in the State of Massachusetts where we are assembled now, they make no requirement at all by law, the matter is left entirely to the individual school. I have found in Massachusetts 67 schools reported and that 33 of them require high school, without the bracing-up that would come from a state-wide canvass



and laws to help to make the thing as stringent as possible, 33 out of 67 of those schools have personally required high schools as a test of efficiency. My figures may vary a little, because I have not had a chance to verify them, but I think they do not vary very much—I found that 9 out of 67 had one year high school standard selected by themselves, and I found that 14 had a common school requirement, that is, out of 67, 33 had high schools, 9 one year in high school, 14 common schools, and further than that there was no report, I do not know about that and I could not trace any further to find any reason. By the time I made that discovery I became interested a little bit in states of the same size, so far as I could think of it without looking up any statistics, I did not have them on the train, but I found North Carolina has a high school requirement by law, but these hospitals reporting were honest enough I suppose to report exactly their position and so out of 35 schools in North Carolina reporting, four of them have a high school requirement, that is almost as many as in New York, if they are good-sized schools, three one year high school and five common school requirement, and of the rest there is no report given. Now alongside of North Carolina with its requirement of the high school by state law, I put Connecticut and looked over the Connecticut list. I find that Connecticut has no requirement by law, it is left to the individual school to settle that matter themselves. Seventeen had reported from Connecticut, 11 of the 17 have a high school requirement and two of them have a one year high school requirement and three a common school. That is, 16 of the 17 reported, only one that no report comes from, but with no requirement whatever. Connecticut does better than New York as to the high school requirement, where there is a very stringent law as to one year in high school. Now take Maryland. Maryland has a high school requirement, 20 had reported from that state, 10 of them have individually adopted high school requirement and are sticking to it, three have one year high school, two have common school requirement and five make no report. Now by the side of Maryland put New Hampshire, which has no requirement. Maryland has a requirement, New Hampshire has no requirement, what do we find? Out of the 14 schools reported six have adopted the high school requirement, three have one year in high school, three of them common school and two of them no report. The state that has no requirement seems to stand higher than the state that has made a pretty stiff requirement. Now I was nearing the capital about the time I completed these statistics, and I was not able to go any further than Pennsylvania, and I tried at Pennsylvania to find out what I could there. They have no requirement in Pennsylvania either, but 37 of the schools make a high school requirement and 15 of them make a one year high school requirement and 36 common school, making 88 out of 115 that are accounted for in this way. Now those statistics are very interesting to me. They may prove one thing to you, they prove one thing to me; to my mind they mean this fact, that every individual hospital and every individual school that is worthy of the name is anxious to lift the standard and keep the standard as high as it can. That is what it means, and the

school in the state that has no requirement—it is singular, I do not know whether it will work that way with the whole 1,100, I have gone with you as far as I have gone with the statistics, but I have taken the important states, you can see, for the most part, the fact is that they all want the best, and if I could I would have a high school standard in every state as the ideal towards which we should move, believing that every hospital that is worth while would aim in that direction. It is evident from this report that a law does little or nothing, because the states without the law apparently give you the better results, but, having put my standard up as high as I thought it ought to be put, if I wished to tone up the hospitals roundabout, or the schools roundabout, instead of making a law that no girl shall come in unless she has had one year in high school, I should make the law that that was the ideal, and I would classify the hospitals according to their success in reaching it. In New York State we have any number of inspectors of all sorts of things, and I think it is not overdone. We can use inspectors with very good results. Take our inspectors of charities, there is no person that comes to your hospital that does more good than one woman who has been doing it for years. When she comes there we go from the top of the building to the cellar and she is full of information, she is guarded as to what she says, and that woman's suggestions are worth while, and so the states might very well hold high ideals up before us and classify us as we were classified in New York as to the upkeep of our property, but let us stop there, for a woman who has not seen the inside of a high school may beat to pieces in nursing the woman that has graduated from college.

PRESIDENT: I think we will have to close discussion on this question. We have a great many more questions to take up.

*Question No. 3.—Who queers the hospital coffee? Is it the dealer, the grinder, the cook, or the server?*

*Is it better boiled or percolated, and how large a quantity of either can be successfully prepared in one lot?*

*Is there an adjustable grinder on the market that will satisfactorily grind for both?*

PRESIDENT: The question is open for discussion, will anyone volunteer? What is the matter with the hospital coffee? I think myself one trouble with hospital coffee is that those late in coming to breakfast get stewed coffee, otherwise it is pretty good. If there is no discussion we will pass on to the next question.

*Question No. 4.—How may justice (financially) be given to patient, doctor and hospital, in case of accident, when the financial responsibility rests with a Liability Insurance Company?*

DR. MANN: I think under the compensation Act in Massachusetts that the hospital and the patient and the doctor are fairly well looked after. You know the law here takes care of the patient for the first two weeks, the doctor is paid, the hospital is paid, and statistics show that something over ninety per cent. of the people who are injured are laid up less than two weeks, so that the hospital gets paid, most of us get \$15 a week, and the doctor gets paid, and then at the end of the two weeks the patient is paid as long as he is laid up, one-half of his salary up to the limit of three weeks, and I think the law is working out first-rate. Of course once in a while the hospital gets the worst of it. We had a case last Fall of a girl that was burned. We got paid \$30 and we kept her over six months. Of course we were not reimbursed for our care, but as I say, over ninety per cent. of the cases recover or go back to work within two weeks of the injury. I think in this state it is going to work out all right. I think perhaps they will change the law a little later and give the hospitals more pay; that is, for longer time.

*Question No. 5.—In some hospitals it is the custom for the nurses on the different floors to have specific duties which involve the partial care of each patient. As for example one nurse takes all the temperatures, another gives all the baths, another writes all the bedside notes, etc. That is, half a dozen nurses may help care for the same patient. In other hospitals the work is so planned that each nurse takes the entire charge of a few patients. Those who are critically ill being cared for by the most experienced nurses. Which of these methods gives the greater satisfaction?*

PRESIDENT: Will Miss Anderson of the New England Baptist Hospital answer this question? Miss Anderson is not here; I will call on Miss Metcalf.

MISS METCALF: I am not prepared to answer this question perhaps as it should be answered, because I am not directly associated with nurses this year, although I have been for many years. Personally I believe that systematic work in the ward goes on much more smoothly if the work is arranged for certain ones in rotation to have certain duties to perform, but I think the individual patient does not like that kind of work. In ward work I think it runs more smoothly and we are sure of getting things done and we know who is responsible for it. In the hospital where I am located now it is our custom for the head nurse of the ward to map out the morning's work and arrange for the fixing up in the morning, bathing, etc., to take charge of a certain number of patients according to the condition of those patients, it may be three, it may be four, and another nurse usually takes all the temperatures, another one gives medicine, and they keep on with those patients until they have them all



fixed up in good shape, and I think that arrangement usually gives satisfaction.

*Question No. 6.—What is the most satisfactory method of calling the different members of the House Staff?*

DR. J. N. E. BROWN: I received your note at the opening of the Convention and have not had time to prepare anything, or make any particular inquiries from members here about this question. My own experience has been in an old-fashioned hospital of using the local telephone to call House officers or to send the hall-boy after them. Most modern hospitals I believe are putting in light systems, signal systems for calling internes. That is being installed in our Detroit General Hospital. I should like very much, if there is time, to hear the experience of some of the members who have tried out the light system.

PRESIDENT: Can any one answer Dr. Brown's question? At the New York Hospital we have a call system which is patterned after the one used in the New York Stock Exchange. Many of you have seen the large board on the side of the room with the numbers that drop. We have these annunciators on each of the wards and in the places where doctors congregate. They are operated from the telephone switchboard. The operator pushes the button and the number is dropped and as it drops there is a small click, just enough to attract attention. If the party wanted does not respond promptly, the operator strikes it again two or three times, producing this light click. We have found it very satisfactory. The only objection is the great expense of installing it. The expense of maintenance is nothing, but the installation costs about \$100 for each annunciator board.

*Question No. 7.—To what extent is anesthesia by nitrous oxide gas displacing ether?*

DR. WASHBURN: I am afraid that I cannot discuss it altogether to your satisfaction. The Lakeside Hospital at Cleveland is using gas and oxygen to a very great extent; to so great an extent that they manufacture their supply and have their operating anesthesia rooms piped. The method with them gives the greatest satisfaction. I have talked with Dr. Ranney, Superintendent, I have talked with Dr. Crile, the surgeon, and Dr. Briggs, and they use it to a very considerable extent. The patient gets under without much discomfort and comes out without much discomfort. They say that the whole attitude of the patients toward an operation has changed since they introduced gas and oxygen anesthesia. The objection to it, as I understand, from the surgeon's point of view is the fact that they do not always get complete relaxation of the muscles. We have done it to quite an extent at the Massachusetts General Hospital, but on selected cases. It is one of our recognized methods of anesthesia and it is increasing in proportion, I think,

each year, but we have not adopted it on any such widespread scale as the Lakeside Hospital. I cannot speak for the other hospitals.

*Question No. 8.—How much and what kind of advertising of the Training School is legitimate? In what periodicals or what papers, etc.?*

DR. HURD: I think it is allowable to advertise in such papers as are liable to bring you the nurses you want for your training schools. I do not see that it is a question that can be answered generally. I have seen a great many training schools that advertise in religious weeklies. I think that is pretty good and that is, of course, absolutely legitimate because they never take anything but the best kind. Then I have seen advertising in medical journals and in the daily papers. I think advertising, if it is in proper terms, is legitimate anywhere.

*Question No. 9.—What is the best method of inducing a municipality to pay incorporated hospitals for the maintenance of its public charges, a per diem rate per patient to cover the actual or approximate expense thereof?*

DR. PETERS: In Providence there is no city hospital, or has not been until within a few years, and the work of that is limited to the care of contagious diseases. There are two hospitals, both private institutions and both were run in arrears financially year after year. The question came up, what should be done, would it be best to limit our work to what we could afford to pay for, would it be best to refuse absolutely such cases as we could refuse if they came to us without financial means, or was it best to go to the city or state and ask them for financial help? That matter was thought over very carefully and our Board of Trustees decided that it was perfectly proper for us to go to the City of Providence and tell the people very frankly what we needed and what we wanted. They had a meeting of the two committees and our people asked for a certain sum of money which they thought would be needed for caring for a very small part of the work that we were doing in the city of Providence, and after due consideration the city of Providence gave us \$25,000 per year without absolutely any restriction. It was given to us as a gift in recognition of the free work which we were doing for the patients in the city of Providence. We do not have to report to any city official what free patients are admitted, we do not have to report how we spend our money, it was simply given as a gift in recognition, with the common sense view that it was cheaper for the city of Providence to give us, an existing hospital, money to help us out at the end of each year than it was for the city of Providence to start another hospital, and that has been going on for some years—six or eight years—without any question, so far as I know,

ever being raised in regard to it. In New York and some of the larger cities, as I understand it, the per capita cost to different institutions for such free patients is reported by the officials of those institutions and they are looked up by the city officials, both in the offices of the hospital and possibly, or probably, at the patient's home. That question has often come up and came up with us directly when we talked of the question of getting money from the city or state, and the question of politics came into it at once. Our people went in a dignified manner, presented a written communication, told them what they wanted, that if they could not get help they would have to restrict free work and the city officials saw it in that light and for a good many years have given us help.

*Question No. 10.—What is the best method of disciplinary treatment for delinquent pay patients in hospitals, other than by transferring them to public wards?*

DR. PRATT: I am afraid it is pretty hard to tell how to get money from people who claim they haven't any, and the best way perhaps is to try to have the business end of the hospital equal the medical and surgical ends. We hear so much about preventive medicine, why not have prevention of losses in the office? Many hospitals I think have the plan of charging the patient in advance, either one week or two weeks, as the case may be, and this prevents, not entirely, but to a large extent, difficulty afterwards in collecting the bills. In case of private patients I have had very little difficulty. As a rule they either have paid in advance without any question, or else they have paid their bills before leaving the hospital. In one or two instances where that has not been the case we have put the bills, after a reasonable length of time, in the hands of a collector and the collector has been very successful. Once in a great while we find a patient who has entered a private room and then ceases payment and when questioned said that they found it was costing them more than they thought it was going to and they did not see how they could pay anything more. In that case do we transfer them to the ward. I have had no experience in hospitals that have a ward for pay patients and another ward for charity patients. Our patients are always put in the same ward, we have only the wards and private rooms. In that case, if they have not paid in advance and the bill is beginning to run, we send someone from the office, usually the bookkeeper, to see the patient, or if the patient is not in condition to be interviewed we have the nearest relative sent to the office when they come to visit the patient. As a rule the patient either pays at that time or arranges to have the relative pay at the next visit. In case they do not do this, the bookkeeper sees them again and tells them that unless they pay up at once their names will be sent in to the city as public charges, as in the minds of all such patients it means calling them paupers. They usually object strenuously to this and will promise to pay at once and in many instances they do so. If they do not do so we send the name to the city, and the city in accepting the case accept it



from the time the name is sent in. We hold this patient responsible for the bill from the time of entering the hospital until the city accepts him, and if he does not pay this bill we put that in the hands of a collector in the same way. We also have one or two little threats we can use, one is, that the patient will become a county charge. We tell them that unless they can pay their bills, as soon as they become convalescent we will send them to the County Hospital. In our county the patients like to go to the County Hospital about as well as patients in Boston like to go to Tewkesbury. The result is, most of the patients pay. There is another threat we have, that is, the patients who are employed by railroads or large corporations, who are very particular about their employees not running into debt, in these cases we threaten to notify the employers of the fact that this employee is not paying his bills and running into debt at the hospital. This usually is very effective and the payment comes very quickly. As I understand, in most instances it means losing their positions if the employers are thus notified. In all cases bills that are not paid are put in the hands of the collector, and we have been very successful in that way. Of course we cannot collect the entire amount, we lose some every year and I suppose always will, but this is the best means we have found of collecting part of it.

**Question No. 11.**—*Should a large hospital (200 to 300 beds) have paid house surgeons in addition to medical and surgical internes?*

DR. HOWLAND (Massachusetts General Hospital): Massachusetts General Hospital has had experience in employing paid house surgeons for about two years. We like it. The fear when this was started was that it would take away the interest in the work formerly done by internes and perhaps prevent the best men from trying for interneship. We are still getting good men. The advantages are that it establishes a much-needed office between the visiting surgeon who can, of course, give comparatively little time to the hospital, and the interne, who is changing rapidly. At the present time a senior surgical interneship lasts only three months. He cannot learn much in general medical surgery in that time. A house surgeon when employed agrees to stay a year and we hope after a year that they will stay longer. The employment of a house surgeon gives the visiting surgeon an extra assistant in very difficult operations, something he cannot get from a constantly changing senior. It provides a man always ready to take care of an emergency case coming to the accident ward or to give his advice in case of an emergency arising in the ward. He is there as a teacher, he teaches the house officer the duties, he is the administrator of the service. The subject of the records of a hospital has already been touched upon, he can go over these same records and perhaps help to fill that gap of twenty-four or twenty-five days that Dr. Hurd spoke of. We have found that they are a great success, they are an invaluable aid to the general administration in innumerable ways, they help discipline, they

tone up the whole service. I do not know anything to say against it.

**Question No. 12.**—*What should be the relationship of matron, dietitian and superintendent of nurses? Should each be independent of the other and responsible to the superintendent only?*

DR. MANN: I think that can be answered in this way: I believe that in a large hospital the Superintendent of Nurses has enough to do to follow up her training school without interfering with the housekeeping or the diet kitchen. I believe that in my own hospital the dietitian while she works with the superintendent of Nurses in teaching the nurses, she is directly responsible to the Superintendent as is the housekeeper. Perhaps in a small hospital, where the Superintendent of nurses is Superintendent of the hospital and has an assistant, etc., it is all right, but I do not think that a Superintendent of Nurses should be burdened with the housekeeping and the kitchen work. She has troubles of her own.

DR. HURD: I suppose the doctor would have them on friendly terms, even have them speak to each other. My experience is that many of them are not even on those terms.

DR. MANN: I have been there nearly fourteen years and there has been very little or no friction. I have had two or three superintendents of nurses in that time and only one housekeeper. Perhaps I am fortunate in having a very fine housekeeper.

**Question No. 13.**—*Is the unitary organization of a hospital preferable to a multiple one? If so, why?*

DR. HORNSBY: It is almost a part of the previous question and I take it it is academic, rather with the purpose of developing the reasons, for the only answer that I see can be made to the question is: a hospital is a machine of many parts and the correlation of all those parts is absolutely necessary to an even running of the machine. If the slightest trouble comes with any part, then the whole machine is out of order, and who is engineer of the machine? I take it, the Superintendent of the hospital. At least in my experience I have found that while there were other people in the institution perfectly willing to take all the authority, I found that when the responsibility came to be fixed, that it came to my office. It does not make any difference whether it is the chief engineer, who has to keep the house warm and who therefore comes into direct contact with the nurses who are responsible for the good comfort of the patient, or whether it is the master mechanic, who must see that the nurses' machinery of various sorts is in proper order, sterilizers, and so on, whether it is the dietitian, who must be responsible to the head nurse and to the doctors for proper food, or whether it is the housekeeper, who must see that the institution is kept clean for the comfort and sanitation of the patient, or whether

it is the head nurse who must be responsible for the care of the patient and who is answerable to the doctor for that care, it does not make any difference which of these departments is out of order, it all focuses in the event of trouble upon the Superintendent of the hospital. I oftentimes think that the Board of Directors of hospitals go far beyond their proper duty when they attempt to dictate anything more than the general policy of hospital administration. I do not believe a Director has any business to tell a Superintendent how to run his institution, I do not think it is any function of the Board of Directors or any member thereof, to interfere with the details of management of a hospital. I have in my own capacity been accused of being a Czar. I have admitted the charge. I do not see how any institution that is charged with the responsibility of a hospital can be administered in a responsible way except by one authority, and that authority in its turn, or in his turn or her turn, can then be held responsible to the people who are supporting the hospital represented by the Board of Directors, not as individuals, but in session. I believe that there can be no question that all the authority centers, all the responsibilities are focused upon the one officer of the institution. I do not see how it is possible for an institution to be administered except under a systematic Czarship, benevolent if you please, humane of necessity, but a Czarship nevertheless.

Question No. 14.—*Is it desirable to have in a hospital of 100 beds or more, a septic unit as well as a contagious unit?*

DR. HOLT: I will say that we do not separate them. We can very easily do it, but from the administration standpoint I do not think it is necessary. We have the closed wards, rooms of three or four beds, that are usually used for that purpose. From the surgical standpoint most of the surgeons do not seem to think it is necessary. Occasionally one asks to have a case removed from the ward, but I do not think it is usually because it is septic, but because it is bad-smelling, or some other reason, and I do not think it necessary to have a septic division. I have in mind one of our oldest wards, one of the hardest wards where there were twelve cases of tuberculous abscesses, and we have not had a single case of infection. It depends entirely upon the house officer or nurse as to whether he will separate them or not. The house officers' work is so arranged that the septic cases are given to one man, usually the third man on the service. The house surgeon or senior interne do not treat any septic cases, and in that way we eliminate the possible infection from nurses on the medical side. On the nurses' side that is watched, of course, by the head nurse, and I will say that we have not had any bad result from having these cases. That is our experience. It is a little different in some other hospitals. I think where a case is isolated, generally, because it is septic, it is apt to be side-tracked. There is no reason why a septic case should not be as well taken care of as a clean case.



Question No. 15.—*What is the plural of sanitarium?*

PRESIDENT: That is a dictionary question.

Question No. 16.—*Have marking machines for marking hospital linen been found satisfactory; if so, which machine is recommended?*

PRESIDENT: At the New York Hospital we use an embroidering machine, sometimes called a bonazing machine, which we have found very satisfactory and which does not require much experience to handle. We can mark a lot of clothing in a short time with it. Our machine is Conely's embroidery bonazing machine, O. J. Ahlstrom, agent, New York.

Question No. 17.—*What is the most satisfactory method of meeting the difference between the receipts and expenditures of a hospital? By annual subscription, advertising campaign, or meeting the deficit yearly as an emergency?*

PRESIDENT: That is a pretty large question at this stage of the meeting.

OLIVER H. BARTINE: (The New York Hospital for Ruptured and Crippled): In answering the question, in my opinion, the following system would seem to be the most adaptable for the average hospital:

All large subscriptions or legacies given to the institution should be placed as specified, or if not specified credited to the endowment fund and when a deficit arises in the general hospital account the treasurer should present a resolution to the Board of Managers that the amount be withdrawn from the endowment fund.

It should be the earnest endeavor of all authorities to inculcate courtesy among their employees, and in that way a generally good impression will prevail which will be of material help when the time arrives for making appeals. In all institutions psychological times arise for bringing your needs to the attention of those who are charitably inclined. A brief specific letter has proven excellent.

I have made it a practice to discuss freely with prospective donors the forms of investments made by our Board of Managers, with the result that our policy has met with universal approval and we have been substantially rewarded by gifts and legacies.

Question No. 18.—*A suggestion as to the easiest method of listing linen.*

Question No. 19.—*Should the private patient department of small hospitals, which are the only hospitals in their respective communities, be open to reputable physicians who are not members of the hospital visiting staff? If so, what restrictions should be placed on the work of physicians treating private patients in the hospital, such as, restrictions on indiscriminate operating, by consultation with members of visiting staff or supervision of operation by same?*

MISS METCALF: Dr. Howell asked me to answer this question. The matter was so thoroughly discussed at a previous session of this conference that there is but little more to say. I understood from that discussion that the general opinion was that large teaching hospitals should be closed hospitals and that small hospitals need to open their doors to other than the staff physicians. In the hospitals which I represent reputable physicians other than the hospital staff may operate and care for patients in private rooms but we have very few such cases, as most of the private cases have one of the hospital surgeons operate. It seems to me the matter of control of physicians or surgeons caring for patients in hospital other than the hospital staff largely cares for itself, for if bad results of indiscriminate operating become known the doctor surely suffers for lack of patients. In any case I believe the superintendent should have liberty to refuse to receive a patient for operation from a doctor known to be unethical. In one closed hospital the doors have been opened guardedly and the burden of responsibility for allowing a doctor other than one of the hospital staff to operate is left in this way. At a regular staff meeting the name of an outside physician is proposed and it may be recommended that he be allowed to operate. In another hospital where outside doctors operate, it is stated in the by-laws that the hospital accepts no responsibility for such cases. I believe that this matter needs to be thoroughly discussed, especially as to its bearing on the record of work in small hospitals when it seems necessary to have an open hospital.

Question No. 20.—*How can the reasonably adequate hospital needs of an industrial city of 30,000 be best determined?*

PRESIDENT: This question was just handed in and no one is prepared to discuss it, I take it.

DR. HURD: That is a question that was sent me a month or six weeks ago, and I said I could not answer it because of insufficient data as to what was meant by an industrial city, if it was an industrial city where they were all engaged in some gainful occupation, where nobody stayed at home, where everybody is busy, in case of accident or sickness there would need to be a very large hospital provision. On the other hand, if the

municipality was a specialized one, where people at home were able to take care of the sick at home, in a great many instances, the hospital would be smaller. I do not think any man on earth can answer the question without knowing about the premises of the whole situation.

DR. CHAS. S. PREST (New York): In the State Charities Association of New York that question has been asked me by the Russell Sage Foundation. My committee, of which I am assistant secretary of New York, is endeavoring to extend hospital facilities in the State of New York for the adequate care of the sick and frequently we are asked by communities of various sizes and character of population and the like, "What are the needs of our community." It has been the previous custom of this committee to make specific surveys, as we all recognize specific communities. For instance, we have just completed a survey of the city of Poughkeepsie and have made recommendations in regard to the additional hospital needs, and by hospital needs I mean adequate care for the sick of the city of Poughkeepsie. Some two years ago we made a survey of the city of Tonawanda, and within a month the Tonawanda people came forth with \$40,000 to construct and equip a hospital from plans such as we recommended as near as possible. Now we appreciate that this is nothing but a guess, but my committee do not object to a guess if you will sufficiently qualify that guess. It cannot specifically state, as for instance in the city of Troy, where there are five women to every man, the hospital needs of the city of Troy are radically different from the hospital needs of a city where the men are employed—in Tonawanda, for instance. The hospital needs of the city of Cohoes, with five women to every man, are radically different from the hospital needs of the city of Canandaigua, because Cohoes is three miles from Troy and nine miles from the hospital, and the hospitals of the city drain the services of Cohoes. Canandaigua, however, is further away and has developed a little medical center of its own and drains a large territory. This question is arising, however, daily, not only in New York State, but everywhere. Within a month I have received correspondence from Texas, where they have asked for the hospital needs of Texas, where 75 per cent. of the population is rural, as regards county hospital needs under their new Texas county law. They are coming to a great extent to that question there and no doubt they are trying to determine that in other communities. I believe that this work would be of the greatest value. I have no desire to attempt it myself. I am approaching this subject with an absolutely open mind, with no prejudice or anything else, but we would appreciate a suggestion and data concerning this. We are ready to go to almost any extent to determine this as reasonably as possible. Dr. Hurd very kindly writes me a long letter explaining specifically his idea and raising the question that he has today and the point is well taken and I have been in conversation with him since. A number of the officers of this Association wrote to me letters explaining very nicely the points, giving me references. We are looking for assistance in this matter and we would be



glad to assist also. The other men gave me specific data, so many beds for men, so much out-patient work and all that, practically no one mentioned the social service feature. All those things, of course, will develop as the work progresses. I appreciate the question came in late, I would like to have any one give it thought and if any information can be gotten to me or suggestions as to how we may go about it, we would greatly appreciate it.

PRESIDENT: Here are three questions sent in. The writer states that these queries are in no sense made in a spirit of fight, but are purely the result of long and careful observation. The questions are as follows:

(1) *Can the efforts of the nursing profession to improve its educational status be rightly regarded as disloyal or harmful to the best interests of hospital organization?*

(2) *How explain the apparent antagonism in some quarters towards the efforts of the nurses to build up their profession?*

(3) *How may the charge that hospital authorities use their training schools for nurses as a means to procure cheap labor be met?*

PRESIDENT: This concludes the Question Drawer, and I think the Literary Program. Is there any business to come before the meeting at this time?

DR. BOYCE: Perhaps it is not known to some of us that this large room has been placed at the disposal of the Association for its meetings gratis, and I think it is only fitting that we should move a vote of thanks to the Manager for doing this. Further I should like to move a vote of thanks to Dr. Holt for his kind attention during the meeting and to the Committee on Arrangements, also to Miss Goodnow for the splendid non-commercial exhibit.

PRESIDENT: The motions are seconded to thank the hotel and Dr. Holt and his committee and Miss Goodnow. All in favor manifest by saying aye. Carried.

DR. HURD: I should like to move a vote of thanks to the officers who have conducted the work of this Association so very successfully. We have had, I think, one of the best meetings we have ever had, and especially I would like to call attention to the fact that for three years we have had the most efficient services of Dr. Brown that we are losing now, it seems to me that we ought to appreciate what he has done for us. I make that motion. (Seconded.)

PRESIDENT: You have heard the motion, that a vote of thanks be extended to the retiring officers, especially to Dr. Brown who has been for three years a very efficient Secretary. All in favor signify by saying aye. Carried.

If there is no further business, I declare the Convention adjourned.

## NON-COMMERCIAL EXHIBIT, AMERICAN HOSPITAL ASSOCIATION, 1913.

### *List of Exhibits.*

#### BOSTON CITY HOSPITAL.

Hospital, house-keeping and nurses' supplies, samples with prices attached.  
Operating room supplies.  
Extension apparatus.  
Dressing car.  
Bath tray.  
Emergency tray.  
Medicine tray.  
One-piece ward bed.  
Bedside table and chair.  
Crib with high sides, designed by Dr. McCollom.  
Photographs.  
Catalogue of rubber stamps.  
Collections of blank forms.  
Diet boards and signs.  
Exhibit of cereals.  
Ward and private trays.

#### NEW ENGLAND SOCIAL SERVICE ASSOCIATION.

Charts, showing methods of work, efficiency tests, follow-up systems, etc.

#### MASSACHUSETTS GENERAL HOSPITAL.

Photographs and models.  
Bed rest.  
Bed raiser.  
Observation stand.  
Restraint jacket.  
Abdominal supporter.  
Chart holder.  
Rectal seepage apparatus.  
Operating cap.

#### INFANT'S HOSPITAL, Boston.

System of records.  
Crib restraint.  
Eczema mask and dress.  
Premature dress.

#### CHILDREN'S HOSPITAL, Boston.

Outdoor wheeled bed.  
Bradford frame on bed.  
Bradford frame on wheels.  
Overhead Extension.  
Bath table.  
Bath tray.

#### BOSTON LYING-IN HOSPITAL.

Breast tray.  
Obstetrical supplies.

## COLLIS P. HUNTINGDON MEMORIAL HOSPITAL, Boston.

Woodfoot support for bed.

Door mat, bag and basket made by handicapped patients.

## MASSACHUSETTS HOMEOPATHIC HOSPITAL.

Catgut sterilizer.

## PSYCHOPATHIC HOSPITAL, Boston.

Photographs and plans of building.

Charts.

## NEW ENGLAND DEACONESS HOSPITAL, Boston.

Support for patient sitting up in bed.

Laparotomy sheet.

Curette sheet.

## EDWARD F. STEVENS.

Hospital footstool.

Ether inhaler (from Copenhagen).

## HOSPITAL FOR THE RUPTURED AND CRIPPLED, New York.

Operating table with plaster attachments.

Toilet racks.

Photographs and plans of building.

## AURORA HOSPITAL, Aurora, Ill.

Plans of building.

## DETROIT GENERAL HOSPITAL, Detroit, Mich.

Photographs and plans of building.

## HEYWOOD HOSPITAL, Gardner, Mass.

Back rest.

## PROVIDENCE CITY HOSPITAL, Providence, R.I.

Combination elbow faucet.

Plans and photographs of buildings.

## RHODE ISLAND HOSPITAL, Providence, R.I.

Invalid lift.

Fracture reducer.

Electric bottle washer.

Food tray.

Bottle holder and carrier.

## U.S. INDIAN SANATARIUM, Fort Lapwai, Idaho.

Outdoor bed cover.

Emergency sputum cup.

## NEW ROCHELLE HOSPITAL, New Rochelle, N.Y.

Improvised incubator.

Lead nipple-shield.

Sides for bed of restless patient.



**RAVENNA HOSPITAL, Ravenna, Ohio.**

Ether dropper.

**DEVEREUX MANSION SANATARIUM, Marblehead, Mass.**

Flower boxes, garden pieces, fireplace brick, etc., with moulds, materials, etc., showing method of making by handicapped patients.

**BRATTLEBORO MEMORIAL HOSPITAL, Brattleboro, Vt.**

Food car (modified McCalmont).

Model of box for shaking dry mops.

**CHOATE MEMORIAL HOSPITAL, Woburn, Mass.**

Operating cap.

**DR. GEO. H. TUTTLE, North Acton, Mass.**

Rectal seepage apparatus.

**DR. GROVES' LATTER DAY SAINTS HOSPITAL, Salt Lake City, Utah.**

Plans of building.

**D. B. ALLEN.**

Adjustable bed rest.

**DR. BLACK.**

Sterilizer control.

**RAINBOW COTTAGE SANATARIUM, Cleveland, O.**

Dolls showing apparatus for surgical correction of infantile paralysis.

Spinal tuberculosis, cervical.

Spinal tuberculosis, thoracic.

Tuberculosis of hip.

Tuberculosis of knee.

Congenital dislocation of hip.

**M. E. MCCALMONT.**

Humane restraint apparatus.

**DR. C. E. TERRY, Jacksonville, Fla.**

Self-restraining gown.

**M. H. CHASE.**

Life size doll for demonstration work.

**W. A. BOWEN.**

Hospital campaign methods and literature.

Heywood bed.

One wheel bed truck.

Liquid soap dispenser with pedal.

**CORRY HOSPITAL, Corry, Pa.**

Bed elevator.

**EXHIBIT OF BLANK FORMS** from about 25 representative hospitals.

## FIRST ANNUAL CONFERENCE

THE ASSOCIATION OF AMERICAN HOSPITAL SUPERINTENDENTS.

Organized at Cleveland O., Sept. 12 and 13, 1899.

The meeting was called to order by Jas. S. Knowles, Superintendent, Lakeside Hospital, Cleveland, O.

*Chairman*

JAS. S. KNOWLES,  
Lakeside Hospital, Cleveland, O.

*Vice-Chairman*

HARRY W. CLARK,  
Supt., University Hospital, Ann Arbor, Mich.

*Secretary*

C. S. HOWELL  
Supt., Western Philadelphia Hospital, Pittsburg, Pa.

*Treasurer*

A. W. SHAW,  
Supt., Harper Hospital, Detroit, Mich.

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## SECOND ANNUAL CONFERENCE.

PITTSBURG, PA.

*Hotel Schenley,*

August 21, 22 and 23, 1900.

*Chairman*

JAS. S. KNOWLES,  
Lakeside Hospital, Cleveland, O.

*Vice-Chairman*

HARRY W. CLARK,  
Supt., University Hospital, Ann Arbor, Mich.

*Secretary*

C. S. HOWELL  
Supt., Western Philadelphia Hospital, Pittsburg, Pa.

*Treasurer*

A. W. SHAW,  
Supt., Harper Hospital, Detroit, Mich.

## THIRD ANNUAL CONFERENCE.

ASSOCIATION OF HOSPITAL SUPERINTENDENTS.

NEW YORK CITY.

*Murray Hill Hotel.*

Sept. 10, 11 and 12, 1901.

*Chairman*CHAS. S. HOWELL,  
Pittsburg, Pa.*Vice-Chairman*F. E. BAKER, M.D.,  
Newark, N.J.*Secretary*JAS. S. KNOWLES,  
Cleveland, O.*Treasurer*A. W. SHAW,  
Detroit, Mich.

## FOURTH ANNUAL CONFERENCE.

PHILADELPHIA, PA.

*Hotel Walton.*

Oct. 14, 15 and 16, 1902.

*Chairman*DR. J. T. DURYEA,  
Supt., Kings Co. Hospital, Brooklyn, N.Y.*Vice-Chairman*DR. CHAS. O'REILLY,  
Supt., Toronto General Hospital, Toronto, Ont.*Secretary*D. D. TEST,  
University Hospital, Philadelphia, Pa.*Treasurer*A. W. SHAW,  
Supt., Harper Hospital, Detroit, Mich.



## FIFTH ANNUAL CONFERENCE.

ASSOCIATION OF HOSPITAL SUPERINTENDENTS.

CINCINNATI, O.

*City Hall,*

Oct. 20, 21 and 22, 1903.

*President*JOHN FEHRENBATCH,  
Cincinnati, Ohio.*Vice-President*CHAS. O'REILLY, M.D.  
Toronto, Ont.*Secretary*DANIEL D. TEST,  
Philadelphia, Pa.*Treasurer*A. W. SHAW,  
Supt., Harper Hospital, Detroit, Mich.

## SIXTH ANNUAL CONFERENCE.

ATLANTIC CITY, N.J.

*Hotel Rudolf.*

Sept. 21, 22 and 23, 1904.

*President*DANIEL D. TEST,  
Pennsylvania Hospital, Philadelphia, Pa.*Vice-Presidents*DR. CHAS. O'REILLY, Toronto General Hospital, Toronto, Ont.  
DR. JOHN M. PETERS, Rhode Island Hospital, Providence, R.I.  
GEO. S. SAWYER, Baptist Hospital, Chicago, Ill.*Secretary*MRS. A. M. LAWSON,  
General Memorial Hospital, New York City.*Treasurer*

DR. A. B. ANCKER, City and County Hospital, St. Paul, Minn.

## SEVENTH ANNUAL CONFERENCE.

ASSOCIATION OF HOSPITAL SUPERINTENDENTS.

BOSTON, MASS.

*Hotel Vendome,*

Sept., 26, 27, 28 and 29, 1905.

*President*

GEO. H. M. ROWE, M.D.

City Hospital, Boston, Mass.

*Vice-Presidents*

DR. CHAS. O'REILLY, Toronto General Hospital, Toronto, Ont.

DR. GEO. E. RICKER, City Hospital, Minneapolis, Minn.

JAS. R. CODDINGTON, New Haven Hospital, New Haven, Conn.

*Secretary*

MRS. A. M. LAWSON,

General Memorial Hospital, New York City.

*Treasurer*

REUBEN O'BRIEN,

General Hospital, Patterson, N.J.

## EIGHTH ANNUAL CONFERENCE.

BUFFALO, N.Y.

*Hotel Niagara,*

Sept. 18, 19, 20 and 21, 1906.

*President*

GEO. P. LUDLAM,

New York Hospital, New York City.

*Vice-Presidents*

DR. RENWICK R. ROSS, Buffalo General Hospital, Buffalo, N.Y.

REV. GEO. C. HUNTING, St. Mark's Hospital, Salt Lake City, Utah.

MISS MARY L. KEITH, Rochester City Hospital, Rochester, N.Y.

*Secretary*

GEO. BAILEY, JR.

Jefferson Medical College Hospital, Philadelphia, Pa.

*Treasurer*

REUBEN O'BRIEN,

General Hospital, Patterson, N.J.

## NINTH ANNUAL CONFERENCE.

AMERICAN HOSPITAL ASSOCIATION.

CHICAGO, ILL.

*Palmer House,*

Sept. 17, 18, 19 and 20, 1907.

*President*DR. RENWICK R. ROSS,  
Buffalo General Hospital, Buffalo, N.Y.*Vice-Presidents*LOUIS B. CURTIS, St. Luke's Hospital, Chicago, Ill.  
W. W. KENNEY, Victoria General Hospital, Halifax, N.S.  
DR. ALICE M. SEABROOKE, Women's Hospital, Philadelphia, Pa.*Secretary*GEO. BAILEY, JR.  
Jefferson Medical College Hospital, Philadelphia, Pa.*Treasurer*ASA BACON,  
Presbyterian Hospital, Chicago, Ill.

## TENTH ANNUAL CONFERENCE.

TORONTO, ONT.

*King Edward Hotel,*

Sept. 29, 30, Oct. 1 and 2, 1908.

*President*S. S. GOLDWATER, M.D.  
Mt. Sinai Hospital, New York City.*Vice-Presidents*J. ROSS ROBERTSON, Hospital for Sick Children, Toronto, Ont.  
JOHN M. PETERS, M.D., Rhode Island Hospital, Providence, R.I.  
RACHEL A. METCALFE, Central Maine Gen. Hosp., Lewiston, Me.*Secretary*W. L. BABCOCK, M.D.  
The Grace Hospital, Detroit, Mich.*Treasurer*ASA BACON,  
Presbyterian Hospital, Chicago, Ill.



## ELEVENTH ANNUAL CONFERENCE.

AMERICAN HOSPITAL ASSOCIATION.

WASHINGTON, D.C.

*New Willard Hotel,**President*

DR. JOHN M. PETERS,

Rhode Island Hospital, Providence, R.I.

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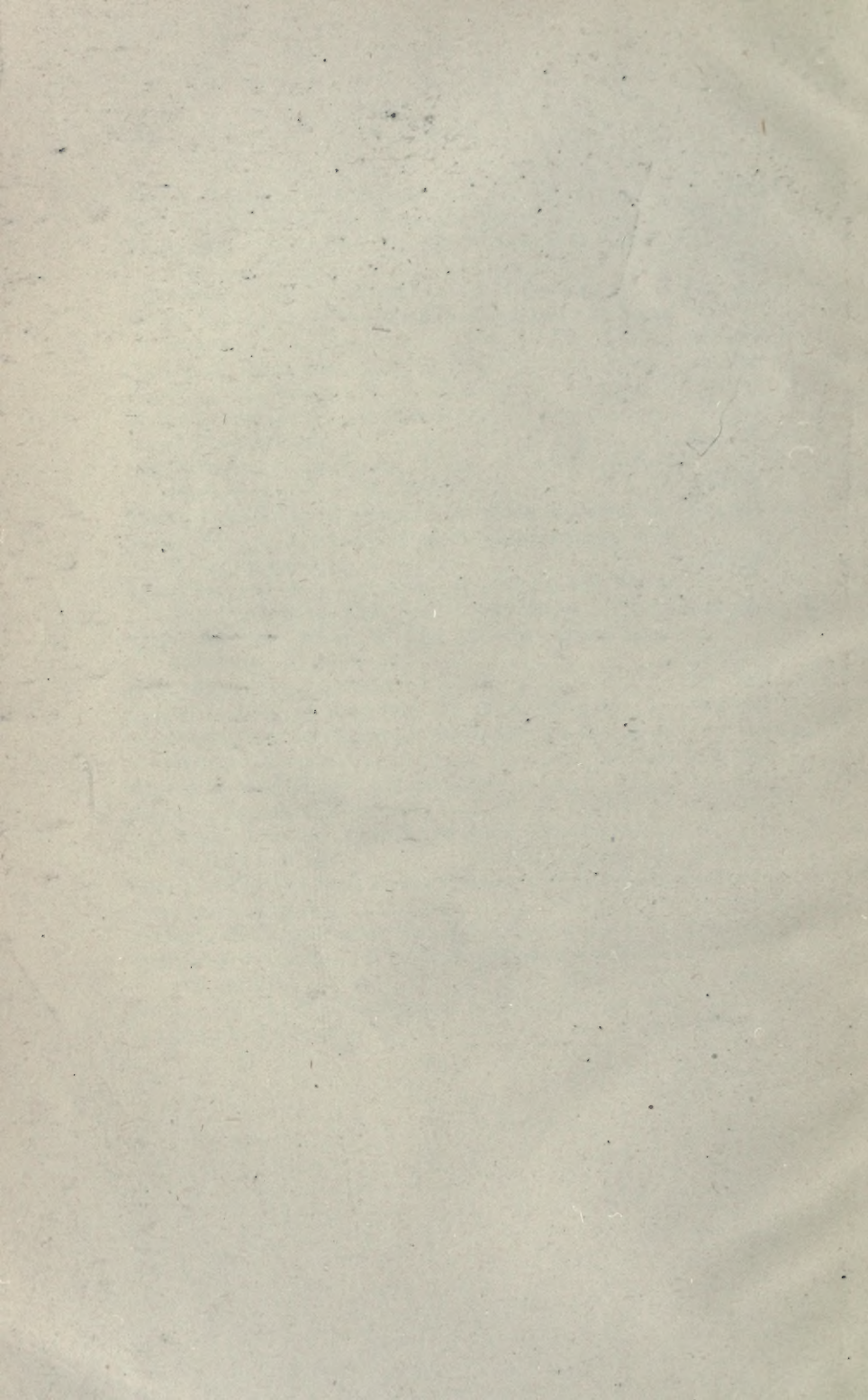


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